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The experiences of clinical psychologists: A systematic review exploring stress, burnout and coping strategies, and a qualitative perspective on working with people with intellectual disabilities and behaviour that challenges

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Empirical Research: 7,419

Chapter 1: Thesis Portfolio Abstract

Background: Stress and burnout is often reported within the 'human service' professions. A systematic review aimed to ascertain the prevalence of stress and burnout within clinical psychologists, and the coping strategies utilised by members of this profession. Specifically, the role of clinical psychologists that work with people with intellectual disabilities and behaviour that challenges may, arguably, be particularly challenging, given the risks inherent in behaviour that challenges. Previous work has found that paid and family carers for this population experience substantial levels of stress. However, little is known about the experiences of clinical psychologists who may play a pivotal role in the multi-disciplinary team supporting individuals and their carers.

Methods: The systematic review explores the prevalence of stress, burnout and coping in clinical psychologists. An electronic review and hand search of the literature was completed. The quality of all eligible articles was assessed, and themes within the findings were discussed using a narrative synthesis approach. The subsequent empirical article explores the perspectives of 14 female clinical psychologists. Thematic analysis was utilised to derive themes from their interview transcripts.

Results: Eight studies met inclusion criteria for the review; findings suggest that a large proportion of clinical psychologists experience symptoms of stress and burnout. Nevertheless, most psychologists also experience high levels of personal achievement in their role. Within the empirical study, two overarching themes were apparent across participants. These included difficult and positive experiences. Participants reported barriers to influencing change and feelings of stress, worry, anxiety, self-doubt and frustration within the role. However, supervision and support from colleagues appeared to moderate difficult emotions. All conveyed a sense of reward within their role.

Conclusions: Comparable to other 'human service' professionals, clinical psychologists experience symptoms of stress and burnout. With regard to clinical psychologists working with people with intellectual disabilities and behaviour that challenges, it

appears that supervision and support from colleagues is key in managing difficult emotions. Based on the findings, provisions that are believed to improve clinical psychologists' experiences are considered.

Lay summary

Background: Stress is a common experience for people that work in health care settings. Clinical psychologists work in health care; their role involves working with people who have mental health problems. A review of research aimed to understand how stressed and burnt out clinical psychologists are, and the coping strategies they use. More specifically, the role of clinical psychologists that work with people with intellectual disabilities and behaviour that challenges may be a particularly stressful job. Other research has suggested that paid and family carers that have close contact with this population, experience high levels of stress. However, little is known about the experiences of clinical psychologists who may play an important role in the team supporting these people and their carers.

Method: The review looks at the reported levels of stress and burnout in clinical psychologists and how they cope. The quality of all included articles was considered, and themes within the findings were discussed. The research article explores the views of 14 female clinical psychologists that work with people with intellectual disabilities and behaviour that challenges, by interviewing them.

Results: Eight studies were included in the review; the findings suggest that lots of clinical psychologists experience stress and sometimes burnout. Yet, most psychologists also experience a sense of reward in their role. Within the completed interview study, two overarching themes were seen across participants. These included difficult and positive experiences. Psychologists talked about barriers to making a difference and feelings of stress, worry, anxiety, self-doubt and frustration within their job. However, many of them thought that supervision and support from people they work with helped them manage difficult emotions. All talked about a sense of reward within their role.

Summary: Just like other health care professionals, clinical psychologists experience stress and sometimes burnout. When thinking about clinical psychologists that work with people with intellectual disabilities and behaviour that challenges, it appears that

their experiences are varied but that support from people they work with is helpful.

Chapter 2: Systematic Review Journal Article

Clinical Psychologists' experience of stress and burnout, and strategies of coping: A systematic review.

Written in accordance with author guidelines for:

Clinical Psychology and Psychotherapy (see Appendix A).

Abbreviated title for running head:

Stress, burnout and coping in clinical psychologists: A review

Keywords

Clinical Psychology

Clinical

Psychologist

Stress

Burnout

Coping

Systematic Review Abstract

Objective: It is well documented that those in the 'human service' profession experience high levels of stress and symptoms of burnout. Considering the impact that stress and burnout can have upon patient care and absenteeism, this review aims to ascertain the prevalence of stress and burnout within clinical psychologists and the coping strategies utilised by them.

Method: Electronic databases were searched for relevant literature. Only those studies that included a measure of stress, burnout or coping within clinical psychologists were included within the review. The quality of all eligible articles was assessed, and themes within the findings were discussed using a narrative synthesis approach.

Results: Eight studies met inclusion criteria. Findings suggest a third of clinical psychologists experience 'caseness' levels of distress and 70% reported being 'very stressed' or 'moderately stressed'. With regard to burnout, around 70% reported symptoms of emotional exhaustion and between 41% and 59% reported levels of depersonalisation in their work. Despite this, between 82% and 95% of psychologists experience high levels of personal achievement. It appears there are few consistent associations between variables such as age and gender and stress. However, there appears to be a relationship between age and symptoms of burnout. Outcomes regarding coping strategies are less clear due to the heterogeneity of outcome measures used across studies.

Conclusions: A large proportion of clinical psychologists report stress and symptoms of burnout; considering the impact this can have on a personal and organisational level, further research assessing the utility of effective coping strategies or stress management techniques within this population is of importance.

Introduction

This review focuses upon the experience of stress and burnout in clinical psychologists. The strategies that are implemented to cope with the demands of the role will also be reviewed. Firstly, each of these constructs will be outlined and discussed.

Models of Stress

Despite stress being used as a term for many decades, there is a lack of consensus on an all-encompassing definition or model of stress (Ader, 1980; Bartlett, 1998; Fernand-Seguin Research Centre, 2007; Goldstein & Kopin, 2009). Selye, in 1936, was the first to recognise the physiological changes that occur due to 'stressors' and the role of the hypothalamic-pituitary-adrenal-axis in the bodily response (Szabo, 1998). That is, when an individual becomes stressed, the hypothalamic-pituitary-adrenal-axis is activated, which results in elevation of the hormone, cortisol (Glaser & Kiecolt-Glaser, 2005). It is important to note that Selye's (1936, 1993) focus was primarily on physical 'stressors' (e.g. fasting, extreme cold), whereas we now know that many causes of stress have a psychological basis and are caused by one's interpretation of events.

Perhaps the most-widely used model in recent times, is the transactional model of stress and coping (Lazarus & Folkman, 1984). Within this model, stress is defined as '*a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources* (1984; p.19)'. In a recent publication of the Handbook of Stress and Health (Biggs, Brough & Drummond), the model was referred to as 'remarkable and has remained the cornerstone of psychological stress and coping research across multiple fields' (2017; p.351). The model emphasised that stress is a subjective concept (Lazarus, 1995), and that no event in itself is inherently stressful; instead, the stressor is defined by the subjective appraisal as harmful, threatening or taxing of resources (Lazarus & Folkman, 1984).

Due to the theoretical and empirical support the Lazarus and Folkman (1984) model of stress has received, stress will be operationalised in line with their definition throughout this review.

Although often viewed in an undesirable light, there are reported benefits of stress. For example, stress is an adaptive response: during acute periods the release of cortisol improves cognitive function and immune response. However, during times of prolonged or intense stress, cortisol can have a negative impact upon, among other things, brain function and immune response, affecting both physical and mental health (Glaser & Kiecolt-Glaser, 2005; Goldstein & Kopin, 2009; Harris et al., 2017; MIND, 2015; Segerstrom & Miller, 2004; Szabo, 1998).

Stress can occur in any number of settings, but one of the most common is the work place; this is defined as occupational stress. The National Institute for Health and Care Excellence (NICE) define occupational stress as '*the interaction between the working environment, the nature of the work and the individual* (NICE, 2009, p9)'. When an individual experiences occupational stress, they perceive the demands and pressure of their role as outweighing their ability to cope (Health and Safety Executive, 2004). There is evidence to suggest that stress is more likely in certain professions, particularly for those that work in the 'human services' (Blau, 1960; Johnson et al., 2005). This is an area of work where the individual might be required to work with people who display intense emotions, who may be at threat of violence in their workplace, and who experience a lack of control over their work (Johnson et al., 2005).

A large-scale European survey reported that stress was highest in education and health sectors, compared to any other occupation group (European Agency for Safety and Health at Work, 2009). These types of roles involve 'emotional labour' where face-to-face work with people requires effort on the individual's part. It has been suggested that workers are unable to display their true emotions when faced with distressing information and/or potentially threatening situations (Zapf, 2002). This includes occupations such as teaching, nursing, healthcare and policing. Occupational stress can lead to high turnover of staff, absenteeism, burnout and reduced efficiency in the workplace (Sutherland & Cooper, 1990).

Measures of Stress

As Amirkhan, Urizar Jr, and Clark (2015) noted, there is not one universally used measure of stress. Physiological measures - such as blood pressure monitoring and testing blood, urine, and saliva for cortisol levels - can be utilised to ascertain an individual's stress reaction. The psychological impact of stress, on the other hand, can be obtained through observation, self-report methods and interviews (Fernand-Seguin Research Centre, 2007).

There are a number of questionnaires that measure stress, such as the Brief Symptom Inventory and Symptom Checklist (see review by Shiralkar, Harris, Eddins-Folensbee and Coverdale, 2013). However, the Perceived Stress Scale is one of the most widely used measures of psychological stress; it measures the degree to which an individual appraises situations in their life as stressful (Cohen, Kamarck, & Mermelstein, 1983). According to the Cohen's Laboratory for the Study of Stress, Immunity, and Disease (Cohen, 2017), the Perceived Stress Scale has been translated into 30 languages other than English and is employed in many publications regarding stress.

Although not originally designed to measure stress, the General Health Questionnaire – 28 item (GHQ-28; Goldberg & Hillier, 1979) has been used to measure psychological distress in this way in numerous studies (for example Darongkamas, Burton, & Cushway, 1994; Draper et al., 2007) and to measure distress linked to occupational stressors. In a systematic review, Goodwin et al. (2013) reported 65 papers used the GHQ-28 for this purpose.

Burnout

A progressive form of stress, particularly in the human service professions, has been labelled 'burnout'. The concept was thought to originate from Freudenberger (1975), and was thereafter further defined by Maslach (1976, see Schaufeli, Leiter, & Maslach, 2009). Burnout is commonly broken down into three constructs. Firstly, emotional exhaustion (EE) is characterised as a lack of energy, or feeling as though emotional resources have been depleted. Secondly, depersonalisation (DP) is defined as treating

clients more like objects rather than people and, finally, a lack of personal accomplishment (PA) relates to feelings of incompetence and lack of achievement in one's work (Maslach & Jackson, 1981). There has been some controversy around burnout, with researchers questioning whether 'boredom' would be a better description of the symptoms (Campagne, 2012). Campagne (2012) theorised that boredom, feeling that one's work is not of much importance (which he termed 'disenchantment' or professional demotivation) within the workplace is often mistaken for burnout. Campagne (2012) suggested that this is rarely identified within professionals, but that this may be more easily remedied than 'burnout', by the use of continued professional education, allowing adequate emotional distance from clients and the use of peer support. An alternative theory is that burnout is purely a form of depression, Bianchi, Schonfeld, and Laurent (2015) conducted a systematic review assessing studies looking at the link between the two constructs and identified 92 studies, but they concluded that the differentiation is fragile. Furthermore, although some studies suggest that burnout is a singular construct, others were considered to be less certain.

Considering there is a lack of certainty for these theories and the fact that the term 'burnout' is still widely used in the literature today, the original definition of burnout by Maslach (1976) will be utilised within this review. When evaluating the relationship between stress and burnout, they appear to be explicitly linked across the literature, with each impacting upon the other (for example, Mcmanus, Winder, & Gordon, 2002). Burnout in healthcare professionals has been found to have a negative impact upon patient care (Rothenberger, 2017) and attendance at work (Borritz, Rugulies, Christensen, Villadsen, & Kristensen, 2006).

Measures of Burnout

Typically, burnout is measured using the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1986) which is split into the three categories discussed above: EE, DP and PA. The MBI does not discriminate between the presence and absence of burnout but rather looks at the symptoms of burnout on a continuum. Scores are split into thirds,

represented as ‘high’, ‘moderate’ and ‘low’ levels of burnout. The Copenhagen Burnout Inventory (CBI; Kristensen, Borritz, Villadsen, & Chrisensen, 2005) is also a validated measure of burnout. It contains three different categories: personal burnout, work-related burnout and client-related burnout. A cut-off is used to ascertain whether a participant is in the ‘burnout range’ or not. Although clarity around which measure has the greatest construct validity is lacking, the MBI is commonly used across the literature base. Within a recent meta-analyses, Wheeler, Vassar, Worley and Barnes, (2011) identified 221 studies that incorporated the use of the MBI within their research.

Coping

Due to the nature of human service roles, a person’s ability to ‘cope’ appears to be key in moderating the possible outcomes of stress and burnout (Jenaro, Flores, & Arias, 2007). Coping is typically defined as adapting both cognitive and behavioural activity to manage demands that are appraised as taxing or exceeding personal resources (Lazarus & Folkman, 1984). This is considered to be a fluid process, where both the situation and the individual’s perception of his or her own ability to cope, can change. However, as Lazarus and Folkman (1984) themselves recognise, there are limitations to this model. For example, when identifying a link between thoughts, coping and stress, as there is a continual feedback loop between these variables which then all impact upon one another. Moreover, the idea of ‘coping’ is fairly broad, and therefore it is not always clear what ‘coping’ looks like (Bartlett, 1998).

Coping behaviours are most commonly classified as either problem- or emotion-focused in the literature (e.g., Lazarus & Folkman, 1984). Problem-focused coping involves generating solutions to solve the problem that is the cause of distress, and taking action by following through a plan. Strategies include learning a new skill or adjusting standards of behaviour. Emotion-focused coping involves a reduction of the emotional distress by implementing strategies such as minimisation, avoidance or wishful thinking. Some coping strategies, such as seeking social support, may involve both problem and emotion-focused functions simultaneously (Vitaliano, Dewolfe, Maiuro, Russo, &

Katon, 1990).

A recent meta-analysis considered the relationship between burnout and coping strategies in 'human service' professions such as teaching and nursing. The findings suggested that problem-focused coping promotes feelings of PA whereas emotion-focused coping reduces symptoms of EE and DP (Shin et al., 2014), thus indicating that each approach is useful.

Measures of Coping

There does not appear to be a single measure of coping that has been consistently used throughout the literature; indeed, a recent review suggested that at least seven different measures have been used to measure this construct (Shin et al., 2014). These included the Coping Orientation of Problem Experience Inventory (COPE; Carver et al., 1989), the Ways of Coping Checklist (Folkman & Lazarus, 1980) and the Coping Inventory for Stressful Situations (Endler & Parker, 1990) to name just a few. It is unclear which would be considered the most reliable and valid measure.

Variables associated with Stress and Burnout

Theoretically and empirically, many factors impact on stress, burnout and the use of coping strategies (European Agency for Safety and Health at Work, 2009). These can be organisational factors such as lack of control or level of responsibility. Rothenberger (2017) identified key organisational factors that impacted upon physician burnout; this included having the autonomy and choice to practice in an area that they personally valued. Zapf (2002) reviewed previous research and concluded that the combination of emotion-work and high workload, time pressure, lack of task control and role conflicts are associated with burnout. Furthermore, Rupert and Morgan (2005) reported that in the 571 psychologists that they surveyed, a strong predictor of burnout was lack of control over work activities, working more hours, spending more time on administrative tasks and paperwork and having to deal with more negative client behaviours. In addition, Emery, Wade and McLean (2009) reported that psychologists' beliefs about control in therapy and inflexibility in their approach were associated with lower levels of PA.

Stevanovic and Rupert (2004) studied licensed psychologists in the US, and they identified that the top rated sources of stress within the job were a sense of responsibility for clients, time pressure and external constraints of services.

Individual factors can play a role too, such as age and gender. For example, research has suggested that younger mental health professionals that are at an earlier point in their career are at higher risk of burnout (Cushway & Tyler, 1996; Lim, Kim, Kim, Yang, & Lee, 2010; Volpe et al., 2014). Gender has previously been found to have an impact, with women reported to be significantly more likely to experience high levels of stress and burnout (Cushway & Tyler, 1994; Freudenberger, 1975; Martin-Johnson, 2016). This could, in part, be due to differential coping strategies utilised by women and men, as in both the general population and mental health professional literature, it appears that males, on a population basis, appear to find it easier to emotionally detach from difficult experiences, whereas females more often seek others and engage in emotion-focused coping (Lawrence, Ashford, & Dent, 2006). In addition, people working in the care profession that are not cohabitating or married are found to be at higher risk for stress and burnout (Soares & Grossi, 2007). It is possible that less available social support may explain this finding.

Both organisational and individual factors appear to impact upon job satisfaction, which seems to be a factor that impacts upon stress and burnout in this population (Rothenberger, 2017; Stevanovic & Rupert, 2004). Considering the complexity of the relationships between stress, burnout and the aforementioned variables, it is difficult to tease these constructs apart to ascertain how much one construct impacts upon another.

Stress, Burnout and Coping in Mental Health Professionals

Mental health professionals would be classed as having a 'human service' job. They work in face-to-face, emotionally demanding settings and have been identified as a professional group who may be particularly vulnerable to occupational stress (Morse, Salyers, & Pfahler, 2012). The role of a clinical psychologist would be categorised under

the umbrella term of ‘mental health professional’. A clinical psychologist works across a range of healthcare settings and is required to assess and treat individuals experiencing a range of mental health difficulties (BPS, 2017b). A recent publication reported on the findings from the British Psychological Society (BPS) and New Savoy Partnership NHS England staff wellbeing survey (Rao et al., 2015). They reported a significant increase in staff stress since the previous year, 70 per cent of professionals that work in psychological services reported that they found their job stressful either ‘often’ or ‘all of the time’, and 46 per cent reported depressed mood.

Furthermore, Cushway and Tyler (1996) published a review, which provided a narrative of findings across various mental health professionals working in the United Kingdom. Their review identified a number of characteristics that were predictive of increased stress in mental health professionals: female gender, early career, not being in a relationship, the use of avoidance coping strategies and reporting low job satisfaction. However, their review was not completed systematically and did not include a homogenous sample as it included studies that incorporated trainee clinical psychologists, psychiatric social workers and counselors. The heterogeneity of the group minimised any ability to compare experiences. A more recent systematic review by Hannigan, Edwards, and Burnard (2004) focused on stress in UK clinical psychologists. They concluded that up to 40% of the population were experiencing ‘caseness’ levels of distress, where they were reaching threshold for significant distress. Both of these reviews concentrated on peer-reviewed literature and clinical psychologists working in the UK. As far as the author is aware, there are no reviews assessing burnout and/or coping within this population.

Review Objectives

The purpose of the current review was 1) to ascertain how many clinical psychologists, irrespective of client group/setting/country, experience stress and burnout and 2) what coping strategies this population utilise. As stress and burnout can have significant impact upon patient care and absenteeism, this review aimed to ascertain the prevalence

of such in this population. Due to the focus on prevalence within this review, only studies with quantitative methodology were included.

Method

The review protocol was registered with the International Prospective Register of Systematic Reviews (PROSPERO), Centre for Reviews and Dissemination (CRD; reference: CRD42017055389). The current review was written in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses statement (PRISMA Group, 2009) in order to ensure that reporting standards were met.

Literature Search Strategy

Searches were conducted in January 2017, and publication year was only restricted by individual database limits. Initial scoping of literature and systematic reviews identified appropriate search terms to locate relevant articles.

The following electronic databases were searched for relevant literature:

- EMBASE (1980 - January 2017)
- Medline (1946 – December 2016)
- PsycINFO (1806 – December 2016)
- ProQuest (1977 – January 2017)
- Clinical Psychology Forum (1985 – January 2017)

These databases were chosen in order to provide broad coverage of relevant published and unpublished literature. The British Psychological Society publication; Clinical Psychology Forum was searched separately as it is not indexed within the listed electronic databases, but could contain potentially relevant articles.
The following search terms were used: "clinical psychologist*" AND (stress OR anxiet* OR burnout OR tension OR worry OR pressure OR depress* OR mood OR rumina*).

NB:* indicates truncation.

The terms were searched within the articles *'keywords'* in EMBASE, Medline and PsycINFO and '*anywhere except full text'* in ProQuest. The Clinical Psychology Forum

does not have a proficient search function; therefore all publications were screened for relevance.

Inclusion Criteria

- Published in English
- Participants were qualified clinical psychologists
- Quantitative methodology
- Utilised a measure of stress, burnout or coping

Study selection procedure

The search selection procedure is outlined in Figure 1. A total of 2917 articles were obtained from five database searches: EMBASE, Medline, PsycINFO, ProQuest and Clinical Psychology Forum. After de-duplication, 1672 papers remained. Titles were screened to assess whether the articles were relevant, and 83 were thought to be potentially relevant. Full texts of these were retrieved and inclusion criteria were reviewed. A total of 76 papers were excluded for the following reasons: four were not published in English, three were not available in full text, two were not empirical research studies, seven were qualitative studies, 23 included professions other than clinical psychologists, (and clinical psychologists could not be differentiated in the analyses), and an additional 12 articles focused on trainee clinical psychologists. Furthermore, 19 articles were excluded as they did not include a measure of stress/burnout or coping, and a further six were excluded as they did not report sufficient data to ascertain levels of stress/burnout/coping in participants.

From this search, seven studies that met inclusion criteria were reviewed further. Reference lists of these articles were then reviewed for relevant articles, with another seven articles being identified, and assessed for potential inclusion. One of these articles met the inclusion criteria. Therefore, eight studies were included in the final review. All excluded articles, and reasons for exclusion are listed in Appendix B.

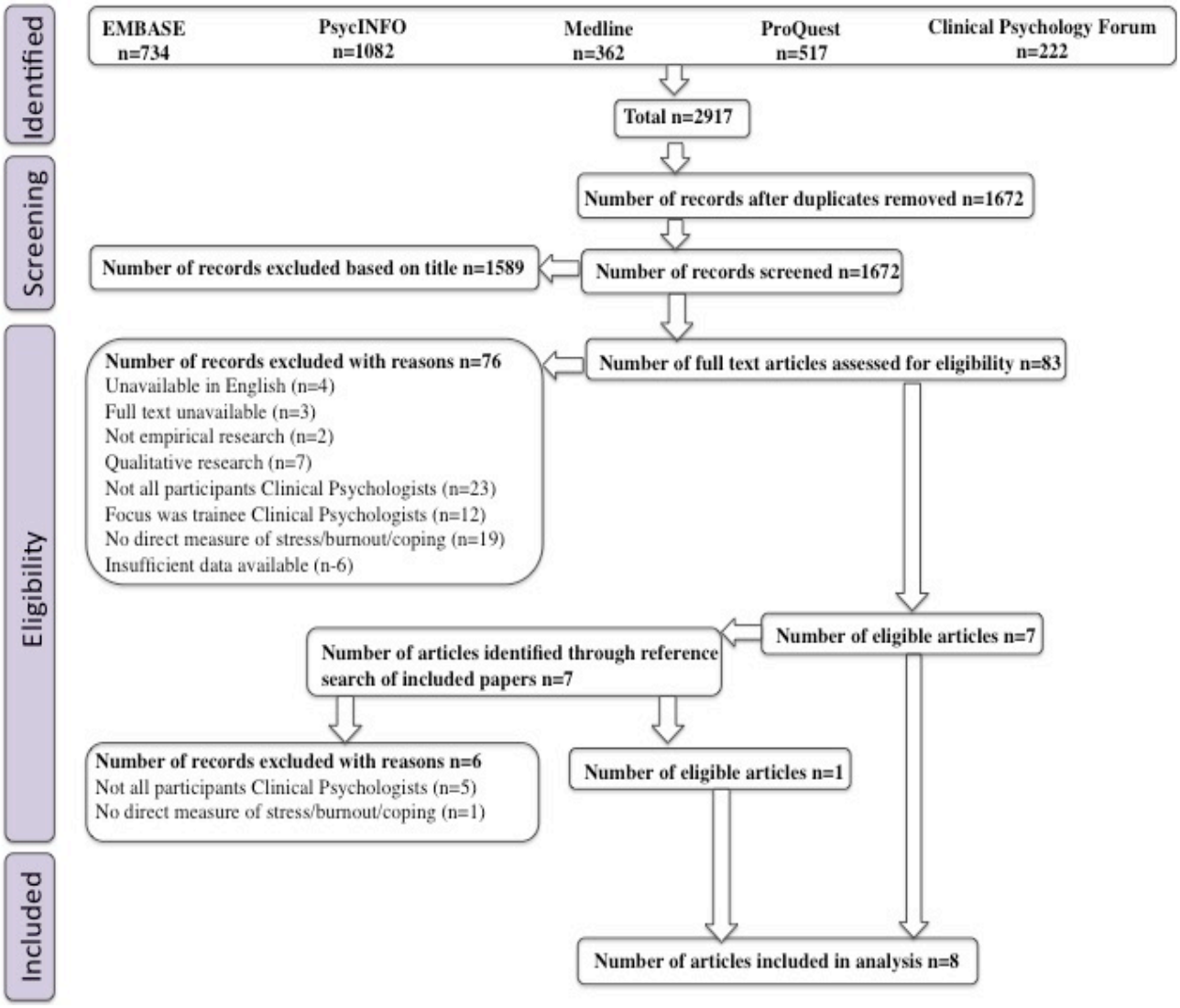

Figure 1: PRISMA flow diagram indicating the procedure followed in order to obtain papers eligible for inclusion in the review.

Results

Data Extraction

Authors (year) *Country*	Sample size (% response rate)	% female	Mean age (range)	Mean years experience (range)	Marital status (% coupled)	Study Aims	Outcome measure			Relevant key findings
							Stress	Burnout	Coping	
Ackerley, Burnell, Holder & Kurdek (1988) *USA*	562 (35.37)	27	44.15 (31-72)	13.8 (1-43)	79	Prevalence of burnout and associated variables	NONE	MBI (1986) PBI*	NONE	***Burnout:*** EE: 39.9% high levels, 32.7% moderate levels. DP: 34.3% high levels, 24.7% moderate levels PA: 0.9% low levels, 3.8% moderate levels PBI outcomes; no overall prevalence information but reports of relationships between a number of constructs such as negative client behaviour and EE, DP and PA. Age and EE negatively correlated $r = -.23$, $p < .01$ and DP $r = -.21$, $p < .01$. Years in service and EE negatively correlated $r = -.17$, $p < .01$ and DP $r = -.15$, $p < .01$. No significant difference between gender/relationship statuses. Those in private practice experienced less EE $F(1, 510) = 4.70$, DP $F(1, 510) = 15.86$, and more PA $F(1, 510) = 43.64$ $ps<.03$ than those in the public sector. Those in private sector were older, earned more, experienced feelings of support more frequently and feelings of lack of control less frequently. High EE profile: young, early career, overinvolvement, feelings of low control, seeing complex clients. High DP profile: early career, feelings of low control, overinvolvement, seeing complex clients. Low PA profile: feelings of low control, low support, high admin load.

Authors (year) *Country*	Sample size (% response rate)	% female	Mean age (range)	Mean years experience (range)	Marital status (% coupled)	Study Aims	Outcome measure			Relevant key findings
							Stress	Burnout	Coping	
Boakes (1998) Unpublished *England*	108 (52.2)	69.4	NR	9.37 (1-29)	NR	Burnout and job satisfaction and how this relates to MDT factors	NONE	MBI (1986)	NONE	***Burnout:*** EE: 46.2% high levels, 28.3% moderate levels. DP: 19.6% high levels, 21.5% moderate levels PA: 0.9% low levels, 16.7% moderate levels. No significant difference in EE between genders t = -1.01, n = 106, p < .317. No analysis on relationship between age and years experience and burnout. Personal role clarity negatively associated with EE r=.408, n=106, p<.001.
Chanofsky (2008) Unpublished *USA*	61 (40)	NR	52.42 (33-69)	NR	NR	Prevalence of burnout and coping strategies	NONE	MBI (1996) EE only	Coping question naire*	***Burnout:*** EE: 17% high levels, 56% moderate levels. No significant correlation between age and burnout r = -.201, p = .121. ***Coping:*** Coping strategies split into cognitive, social and physical techniques: No significant relationship between cognitive r = .010 p = .939, social r = -.043, p = .741 or physical techniques r = .007, p = .959 and burnout. No significant relationship between cognitive r = -.002, r = .987, social r = .005, r = .970 or physical techniques r = -.151, r = .247 and age. Qualitative results suggest that self care strategies results in lower levels of burnout.

Authors (year) *Country*	Sample size (% response rate)	% female	Mean age (range)	Mean years experience (range)	Marital status (% coupled)	Study Aims	Outcome measure			Relevant key findings
							Stress	Burnout	Coping	
Cushway & Tyler (1994) *England*	101 (67)	60	37.6 (25-61)	10 (1-31)	Males: 93 Females: 69	Prevalence of stress and coping	SS (1988) GHQ-28 (1978)	NONE	Coping section of HDL form (1984) plus 7 added questions	***Stress:*** 20% very stressed, 55% moderately stressed. Negative correlation with age r=-.292, p<.001 and number of years practising r=-.208, p<.05. 29.4% at caseness on GHQ Women significantly higher GHQ scores than men $F(1,98) = 6.118$, $p < .05$. Higher GHQ scores correlated with being single $r = 0.17$, $p < .01$. Those that reach caseness on GHQ younger $F(1,99) = 5.587$, $p < .02$ and practising for fewer years $F(1,98) = 10.726$, $p < .002$. Higher GHQ scores for those in supervisory role r=0.204, p<.01 ***Coping:*** 65% used behavioural and 60% cognitive. GHQ cases more likely to use avoidance coping $F(1,69) = 4.723$, $p < .05$

Authors (year) *Country*	Sample size (% response rate)	% female	Mean age (range)	Mean years experience (range)	Marital status (% coupled)	Study Aims	Outcome measure			Relevant key findings
							Stress	Burnout	Coping	
D'Souza, Egan & Rees (2011) *Australia*	87 (N/A)	86	18 (20-30) 32 (31-40) 20 (41-50) 11 (51-60) 6 (60+)	34 (1-5) 25 (6-10) 12 (11-15) 5 (16-20) 11 (20+)	NR	Relationship between perfectionism, stress and burnout	DASS-21 (1995)	CBI (2005)	NO NE	***Stress:*** 1% severe stress range, 1% moderate range and 6% mild range. Remainder in normal range. No significant relationship between age $r = -.08$, $p = .34$ or gender; $z = -1.73$, $p = .08$ and stress. ***Burnout:*** 8% in burnout range. Age significantly negatively correlated with client-related burnout $r = -.25$, $p = .01$, work-related burnout, $r = -.32$, $p = .002$ and personal burnout, $r = -.24$, $p = .02$. Females significantly higher personal burnout $z = 3.19$, $p = .001$, work-related burnout $z = -3.16$, $p = .002$. No gender differences in client-centered burnout $z = -1.72$, $p = .07$. Perfectionism significantly correlated with stress $\beta = .444$, $p = .000$ and personal burnout $\beta = .247$, $p = .019$, work related burnout $\beta = .282$, $p = .007$ and client related burnout $\beta = .284$, $p = .009$. Perfectionism correlated with age $r = -.29$, $p = .005$. Younger psychologists scored higher.

Authors (year) *Country*	Sample size (% response rate)	% female	Mean age (range)	Mean years experience (range)	Marital status (% coupled)	Study Aims	Outcome measure			Relevant key findings
							Stress	Burnout	Coping	
Murray (1990) Unpublished *Scotland*	115 (59)	68	37.8 (26-63)	10.8 (<1– 37)	NR	Role stress and job satisfaction	GHQ-28 (1979)	NONE	NONE	***Stress:*** 33% at caseness on GHQ-28. No significant difference between GHQ-28 scores and gender $F(1,112) = .07$, $p = .79$. A sense of role conflict significantly correlated with GHQ score $r=.31$, $p=.001$.
Rao & Mehrotra (1998) *India*	116 (60)	36	42.1 (25-65)	15.21 (1-37)	88	Prevalence of stress, correlates of this and coping strategies	MHPSS (1996)	NONE	Open ended question	***Stress:*** Low levels of stress rated on MHPSS, mean is well below the mid-point of the scale. (No further detail given). Age, gender, relationship status did not influence stress level (no statistics provided). However, those working across multiple settings, or working full time in an outpatient based service and those seeing one diagnostic group for more than 50% of their time had higher MHPSS scores. Professional stress negatively correlated with professional role satisfaction $r=.28$, $p<.01$. ***Coping:*** Emotion-focused coping most frequently used (67%) e.g. distraction/relaxation, 66% utilise social support and 44% use problem-focused techniques. No analysis on impact of coping on stress.

Authors (year) *Country*	Sample size (% response rate)	% female	Mean age (range)	Mean years experience (range)	Marital status (% coupled)	Study Aims	Outcome measure			Relevant key findings
							Stress	Burnout	Coping	
Sampson (1989) Unpublished *Scotland*	108 (67)	62	37.5 (NR)	NR	69	Role stress and coping strategies used	SS (1988) GHQ-28 (1979)	NONE	Coping section of HDL form (1984) PLUS 8 added questions Ranking of coping strategies used	***Stress:*** Extent of stress; 16% stated very stressed, 47% moderately stressed. Total stress survey scores did not correlate with age r = .11, p = .25, number of years experience r = .14, p = .14. There was no difference in stress survey scores across gender T = -.07, p = .94 or coupled/uncoupled psychologists T = 1.18, p = .25. 33% of CPs above threshold for psychological disturbance on GHQ-28. Stress survey correlated with GHQ r = 0.38 p < .001. SS: Significant difference between principal CPs and Senior CPs F(3,104)=2.92, p<.05 and significantly lower stress scores in CPs with children living at home T=2.3 (1,106), p=.02. No significant difference between specialities or supervisors/non-supervisors. ***Coping:*** HDL-18% used active cognitive strategies, 21% used active behavioural and 5% used avoidance. Ranking top 5– 56% talked to other clinical psychologists, 35% talked with spouse/relative, 32% partook in hobbies, 32% tried to organise time better and 28% took time off/holiday. No further analyses on this.

Table 1: Summary of study data

Terms: CPs – Clinical Psychologist MDT - Multi-disciplinary team; EE – emotional exhaustion; DP – depersonalisation; PA – personal accomplishment
Measures: MBI – Maslach's Burnout Inventory (Maslach & Jackson, 1986); GHQ-28 – General Health Questionnaire (Goldberg & Hillier, 1979); DASS-21 - Depression, anxiety and stress scale (Lovibond & Lovibond, 1995); CBI - Copenhagen Burnout Inventory (Kristensen et al., 2005); MHPSS - Mental Health Professional Stress Scale (Cushway, Tyler, & Nolan, 1996); HDL – Health and Daily Living Form (Moos, Cronkite, Billings, & Finney, 1984); SS – Stress survey (adapted from Cushway, 1988). *PBI - Psychologist's Burnout Inventory. *developed by author

Assessment of quality of included studies

A quality assessment tool was developed to assess the methodological quality of the included articles. As noted within the CRD (2009) guidance, differentiating between reporting quality and methodological quality has its challenges. If reporting quality is favoured, this could influence the interpretation of the strength of evidence. This was held in mind when quality of the included papers was assessed. There is no single recommended reliable and valid checklist suitable for assessing the quality of studies (CRD, 2009), and therefore the measure that was developed drew on a number of existing guidelines, namely those from The Joanna Briggs Institute (2016), The CRD (2009) and the Agency for Healthcare Research and Quality (2002). Ten aspects of each study were assessed, covering a range of criteria including representativeness of sample, choice of measure, statistical analyses and conclusions drawn. These criteria can be found in Appendix C. For each of the ten criteria, a study could score: 2 – indicating the criterion was well covered (top category); 1 – signifying the criterion was adequately addressed or 0 – meaning the criterion was poorly or not addressed. The scores for the quality criteria are shown in Table 2.

The primary researcher carried out data extraction and quality assessment for all eight studies and an independent researcher carried out quality assessment for four randomly selected papers (50%). Cohen's κ was used to determine rate of agreement between reviewers (Cohen, 1960). Based upon criteria developed by McHugh, (2012) there was a 'strong' agreement between the reviewer, $\kappa = .808$, 95% CI [.649, .967], $p < .001$. Any discrepancies in scores were discussed between reviewers and a joint decision was reached, resulting in a single rating.

Regardless of the quality score, all eligible studies were included in the review given that they met inclusion criteria. A meta-analysis was inappropriate due to variation in methods and measures, which meant that it was not possible to combine outcomes. Therefore critical appraisal of the studies is narrative in format and is structured around the variables each of the included papers investigated.

	Aims/ Hypotheses	Ethics	Sample	Response rate	Missing data	Quality of measures	Participant demographics	Statistical analyses	Conclusions	Limitations
Ackerley et al (1988)	2	0	0	1	0	2	1	1	2	2
Boakes (1998)	1	2	1	1	0	2	0	1	2	2
Chanofsky (2008)	2	0	0	1	2	0	0	2	1	1
Cushway & Tyler (1994)	1	0	1	1	0	0	2	1	2	0
D'Souza et al (2011)	1	2	0	0	0	1	1	2	1	2
Rao & Mehrotra (1998)	1	0	1	2	2	1	2	1	2	2
Murray (1990)	0	0	1	2	0	2	1	1	2	2
Sampson (1989)	1	0	1	2	0	1	1	1	2	1

Table 2: Quality criteria rating for each study

Characteristics of included studies

Study details are summarised in Table 1 and provide the following information: sample size, response rate, participant demographic information (age, gender, number of years experience, relationship status), study aims, outcome measures and relevant findings. Although all papers included participants of various ages and this was fairly consistent across the studies, the distribution of gender was highly variable ranging from 27% to 86% female. While the total sample numbers are relatively high, this variation will be held in mind.

All eight papers adopted a cross-sectional design, with questionnaires sent via post or email for participants to complete. Four studies were peer-reviewed articles, and the remaining four were unpublished dissertations. Three of the studies reported both stress and coping in clinical psychologists, one focused mainly on stress and two on burnout. Of the remaining two papers, one reported burnout and coping and the other concentrated on stress and burnout.

The measures used for each construct was varied; although some relied upon one measure of each, others included an additional measure, and in some instances this was developed by the authors themselves. For example, with regard to stress, three of the studies (Cushway & Tyler, 1994; Murray, 1990; Sampson, 1989) used the GHQ-28. Both Murray (1990) and Sampson (1989) included the Stress Scale alongside the GHQ-28. However, D'Souza et al. (2011) and Rao and Mehrotra (1998) adopted the Depression, Anxiety and Stress Scale – 21 item (DASS-21; Lovibond & Lovibond, 1995) and the Mental Health Professionals Stress Scale (MHPSS; Cushway et al., 1996) respectively and used these independent of additional measures.

When measuring symptoms of burnout, either the MBI (Ackerley et al., 1988; Boakes, 1998; Chanofsky, 2008) or the CBI (D'Souza et al., 2011) was adopted. In addition, Ackerley et al. (1988) developed the Psychologist's Burnout Inventory (PBI) to use alongside the MBI. With regard to coping, only two papers used a similar questionnaire, with both Cushway and Tyler (1994) and Sampson (1989) adapting the Health and Daily Living (HDL) form. In addition, three papers utilised a measure that was developed by the authors themselves. Sampson (1989) asked

participants to rank the coping strategies they use, Chanofsky (2008) developed a coping questionnaire containing eight items and Rao and Mehrotra (1998) included an open ended statement about coping within their questionnaires, the content of the statement was unspecified. These additional coping measures were not assessed for validity or reliability within the papers.

Study Quality

Table 2 provides the quality ratings for each of the 10 criteria. A total score for each paper is not used within this review. Each criterion may be differentially important, and therefore a weighting scheme would be required. However, this would introduce additional subjectivity into the process and was not considered to be of sufficient benefit.

Overall, the quality of the studies was fairly low; none of the included studies fully reported the representativeness of the population, which makes it difficult to ascertain the generalisability of the findings. However, they did all report the response rate, which ranged considerably from 35% (Ackerley et al., 1988) to 67% (Cushway & Tyler, 1994; Sampson, 1989).

The recruitment method varied; four authors contacted heads of psychology in their respective localities (Boakes, 1998; Cushway & Tyler, 1994; Murray, 1990; Sampson, 1989) whereas others recruited participants via their Professional, Statutory and Regulatory Body. For example Ackerley et al. (1988) and Chanofsky (2008) recruited via the American Psychological Association, and Rao and Mehrotra (1998) via the Indian Association of Clinical Psychology. D'Souza et al. (2011) relied upon volunteers responding to advertisements distributed via various Australian professional bodies to take part.

Only three of the studies fully reported the validity and reliability of the measures they adopted (Ackerley et al., 1988; Boakes, 1998; Murray, 1990) and none of the papers discussed the characteristics of the psychologists that were approached to partake in the research but decided not to.

Only two of the studies (Cushway & Tyler, 1994; Rao & Mehrotra, 1998) reported

all four of the participant demographics that this review was concerned with, but the majority included three out of the four, which allowed for partial comparison. Only two of the included articles completed all relevant and possible correlational analyses (Chanofsky, 2008; D'Souza et al., 2011). Half of the studies were balanced in the reporting of their conclusions; neither over nor understating their findings (Ackerley et al., 1988; Boakes, 1998; Cushway & Tyler, 1994; Murray, 1990). The majority of studies took the limitations of their research into account.

With regard to which papers would be considered as good quality within this review, the criteria that were felt to be most important were the response rate and how representative the sample was of the larger population. Considering this, the following papers were felt to be of good quality compared to others; Rao and Mehrotra (1998), Murray (1990), Sampson (1989), Cushway and Tyler (1994) and Boakes (1998).

Summary of main findings

Prevalence of stress

Five papers explored stress in clinical psychologists. Of those that adopted the GHQ-28, Cushway and Tyler (1994) reported that 29.4% of the sample were above the threshold for psychological disturbance, at 'caseness', and both Murray (1990) and Sampson (1989) found that 33% of their sample were considered above threshold. Both Cushway and Tyler (1994) and Sampson (1989) used the Stress Survey (SS) in addition to the GHQ-28; Cushway and Tyler (1994) reported that 20% of the sample were 'very stressed' and 55% were 'moderately stressed', compared to 16% 'very stressed' and 47% 'moderately stressed' in Sampson's (1989) sample. These three studies had a very similar response rate, number of participants, gender distribution and were all conducted within the UK. This could explain the reason for the similarities in their findings.

When using the DASS-21, D'Souza et al. (2011) reported that 1% of the sample were 'severely stressed', 1% were 'moderately stressed', and 6% were considered in the 'mildly stressed' range, with the remainder in the 'normal' category. Rao and Mehrotra (1998) reported, using the MHPSS, that there were low levels of stress

across participants. These results indicate far lower stress levels than identified in the other papers. This may be due to variation in the measures used across studies; however, D'Souza et al. (2011) and Rao and Mehrotra (1998) were conducted in Australia and India respectively. It is a possibility that there is a lower incidence of stress within these countries compared to the UK; this might be due to healthcare provision or workplace organisation. However, it is not possible to draw any firm conclusions regarding this due to the different measures administered.

Variables associated with stress

There was found to be no significant association between reported stress levels and gender (D'Souza et al., 2011; Murray, 1990; Rao & Mehrotra, 1998; Sampson, 1989), relationship status (Rao & Mehrotra, 1998; Sampson, 1989), age (D'Souza et al., 2011; Rao & Mehrotra, 1998; Sampson, 1989) or number of years of experience (Sampson, 1989) in the majority of studies. However, in contrast, Cushway and Tyler (1994) reported that being female, single, young, and an early career psychologist are associated with higher scores on the Stress Scale and GHQ-21.

A number of additional variables were presented across studies. Cushway and Tyler (1994) and Sampson (1989) discussed the effect of being a supervisor on stress levels. Cushway and Tyler (1994) reported higher scores on the GHQ measure for those in a supervisory role compared to those that were not, whereas Sampson (1989) found no difference in Stress Scale scores across these two groups. Although it is difficult to draw any conclusions due to the lack of evidence across studies, D'Souza et al. (2011) reported that perfectionism was significantly correlated with stress and Rao and Mehrotra (1998) discovered that clinical psychologists working across multiple settings, or working full time in an outpatient setting and those working with one diagnostic group of patients for more than half of their time had higher stress scores. In addition, Murray (1990) reported that a sense of role conflict (having many dissonant tasks) was correlated with higher GHQ scores.

Prevalence of burnout

Across the four papers that studied burnout, the three that used the EE section of the MBI reported a similar prevalence of symptoms of EE. Ackerley et al. (1988)

reported 46.2% in the 'high range', 28.3% in the 'moderate range' (74.5% total in 'high' or 'moderate range'), Boakes (1998) reported 39.9% in the 'high range' and 32.7% in the 'moderate range' (72.6% total in 'high' or 'moderate range') and Chanofsky (2008) reported 17% in the 'high range' and 56% in the 'moderate range' (73% total in 'high' or 'moderate range'). Considering the location of this research varied (UK and US), and the gender distribution varied considerably (between 27% and 69.4% females), the similarities observed are particularly noteworthy.

Levels of DP were slightly more varied across the two studies that measured this; Ackerley et al. (1988) reported that 34.3% of the sample were classified as being in the 'high range', and 24.7% in the 'moderate range' (59% total in 'high' or 'moderate range') whereas Boakes (1998) reported that 19.6% were in the 'high range' and 21.5% in the 'moderate range' (41.1% total in 'high' or 'moderate range'). This could suggest that psychologists in the US experience higher rates of DP than those in the UK. However, there was also a vast difference in gender between these studies, with only 27% of the sample being female in Ackerley et al. (1988) compared to 69.4% in Boakes' (1998) research. Therefore, it was difficult to draw conclusions regarding the reason for the observed variation in DP.

When focusing on PA, this also varied between the two papers that assessed this; Ackerley et al. (1988) reported that 0.9% of the sample were classified as being in the 'low range', and 3.8% in the 'moderate range' (4.7% total in 'low' or 'moderate range'), whereas Boakes (1998) reported that 0.9% were in the 'low range' and 16.7% in the 'moderate range' (17.6% total in 'low' or 'moderate range'). This suggests that the majority of the population (between 82.4% and 95.3%) would be in the high range of PA, indicating they possess a sense of achievement within their role.

D'Souza et al. (2011) utilised the CBI to measure burnout. The CBI gives an overall score and D'Souza et al. (2011) reported that 8% of the sample were in the 'burnout range' and the remainder in the 'normal range'.

Variables associated with burnout

When looking at variables that correlated with burnout, Ackerley et al. (1988) and

Boakes (1998) reported that there was no relationship between gender, whereas D'Souza et al. (2011) stated that women had higher levels of personal and work related burnout, but not client-centered burnout. Chanofsky (2008) did not report gender distribution in their study. D'Souza et al. (2011) reported that younger psychologists were more likely to experience personal, work-related and client-related burnout; the conclusions from Ackerley et al. (1988) support this as they reported a relationship between younger psychologists and higher levels of both EE and DP. When it comes to the number of years experience, the results are conflicting: Boakes (1998) suggested there is no relationship, whereas Ackerley et al. (1988) indicated that the fewer years of experience that a psychologist has the more likely they are to experience high levels of EE and DP. Ackerley et al. (1988) reported that there was no significant correlation between relationship status and burnout.

A number of additional variables that impacted upon burnout were presented across studies. Ackerley et al. (1988) reported that those in private practice experienced less EE, DP and higher levels of PA than those in the public sector. However, those in the private sector were older, earned more, experienced feelings of support more frequently and feelings of lack of control less frequently. They also reported associations between high EE and DP scores and over-involvement with patients, feelings of low control and seeing complex cases. Those with lower PA scores experienced feelings of low control, low support and a high administration load. D'Souza et al.'s (2011) results indicated perfectionism is related to personal, work related and client related burnout. Boakes (1998) reported that a lack of personal role clarity was associated with higher EE scores.

Use of coping strategies

The methodologies employed across the four studies that examine coping styles differ, making comparison difficult. Both Cushway and Tyler (1994) and Sampson (1989) adapted the Health and Daily Living Form (HDL; Moos, Cronkite, Billings, & Finney, 1984) by adding either seven or eight additional questions (at least two of the questions differed across the studies). This measure is not a validated or widely used tool to measure coping. However, Cushway and Tyler (1994) reported that 60% of the sample used behavioural strategies (such as organising time more efficiently)

and 65% used cognitive strategies (such as taking a step back from the situation and viewing it more objectively). In comparison, Sampson (1989) reported that 21% used active behavioural strategies, 21% used active cognitive and 5% used avoidance strategies. Only one study quantified the coping styles into emotion- and problem-focused as Folkman and Lazarus (1980) suggested. Rao and Mehrotra (1998) reported that 67% of psychologists used emotion-focused coping and 44% used problem-focused coping based on their open-ended question.

Variables associated with coping strategies

Although Cushway and Tyler (1994) did not report the prevalence of avoidant coping, they reported that psychologists that were avoidant were more likely to score at 'caseness' on the GHQ-28. Investigation to ascertain any relationship between coping strategies and stress levels was not completed in Rao and Mehrotra's (1998) study. Although Chanofsky (2008) did not report the incidence of coping strategies use in psychologists, they did report that there was no significant relationship between cognitive, social and physical techniques and EE scores. In addition, the coping questionnaire developed by Chanofsky (2008) found no association between coping style and burnout however, within their qualitative findings they reported that the use of self-care strategies appear to result in lower levels of burnout. Furthermore, no associations between age and number of years experience, gender, and relationship status and coping strategies were assessed within these studies.

Discussion

The majority of included studies did not focus exclusively upon the prevalence of stress, burnout and coping strategies applied by participants. However, of those that did report relevant findings, the main findings are summarised and discussed.

Stress

Around a third of clinical psychologists experience 'caseness' levels of psychological distress; this rate of 'caseness' is slightly lower than the 40% reported in Hannigan, Edwards, and Burnard's (2004) review. The evidence from the included studies suggests that 70% of psychologists reported being either 'very stressed' or 'moderately stressed' which is in line with the recent BPS survey of psychological professionals (Rao et al., 2015). Cushway and Tyler (1996) previously suggested that there were higher rates of stress in single, female mental health professionals with fewer years' post-qualification experience. However, this current systematic review of the evidence does not support these conclusions in relation to clinical psychologists specifically.

Burnout

Based upon the evidence, approximately 73% of clinical psychologists experience symptoms of EE in the 'high' or 'moderate range' and between 41% and 59% experience symptoms of DP in the 'high' or 'moderate range'. However, there is evidence to suggest that the majority of psychologists experience high levels of PA in their work (between 82 and 95%). There was little consistent evidence, across studies, that there is a link between burnout and the following variables: gender, relationship status and number of years experience. However, a possible relationship between age and burnout (that younger psychologists reported increased levels of burnout) was reported in two of the included papers (Ackerley et al., 1988; D'Souza et al., 2011); this supports aforementioned findings (Lim et al., 2010; Volpe et al., 2014).

It appears there may be other variables that impact upon stress levels and burnout, such as role conflict (Murray, 1990), pefectionism (D'Souza et al, 2011), over-

involement with patients and feelings of low control (Ackerley et al., 1988). However, a stronger evidence base and further analyses would need to be conducted in order to draw firm conclusions regarding these variables.

Coping

Due to the heterogeneity of measures and classification of coping, it was difficult to draw conclusions about the types of coping strategies used. Ideally, all studies would have classified coping strategies into problem and emotion focused coping to enable comparison between studies and with prior research, as identified by Folkman and Lazarus (1980). However, only Rao and Mehrotra (1998) chose to do so. Based on this study, it does appear that emotion-focused strategies are slightly favoured over problem-focused strategies. Based upon the remaining evidence available, it appears that clinical psychologists use cognitive strategies an equivalent amount to behavioural strategies. It is not possible to conclude whether the use of these are sufficient in reducing stress levels or symptoms of burnout as this analysis was not completed. However, it does appear that avoidant coping may be detrimental to psychological wellbeing. Analysis to assess for associations between coping and gender, relationship status, age and number of years experience was not completed within these studies.

Associations between stress, burnout and coping

From the limited evidence available, there appeared to be little association between coping strategies, stress levels and burnout. Of the eight studies, only Cushway and Tyler (1994) reported outcomes of both stress and burnout, but unfortunately they did not attempt to assess the relationship between the two. Therefore, this does not allow for comment on the possible link between stress and burnout previously reported in the literature (McManus et al., 2002). Cushway and Tyler (1994) did not observe a relationship between coping and burnout, but they did report that avoidant coping was associated with psychological distress.

Variation across countries

Healthcare provision across the countries that were included within this review is diverse. The USA and Australia implement a predominantly private health insurance

system, India utilises a mixture of private and state funded (dependent on income) and the UK provides a primarily state funded National Health Service (NHS). Rates of reported stress appeared to be the main difference across countries with consistently higher rates in the UK. This perhaps suggests that working within a government funded NHS is associated with higher stress levels and risk of burnout. This was supported by Ackerley et al.'s (1988) findings that those in the private sector in the USA experienced less EE and DP and higher levels of PA. However, different measures were used across studies, which makes it difficult to draw firm conclusions.

Implications and future research

This review suggests that a significant proportion of clinical psychologists report symptoms of stress and burnout. Stress and burnout adversely affect an individual's wellbeing, and in turn impact upon sickness absence rates and, potentially, effectiveness in therapy (Rupert & Morgan, 2005). This leads to speculation of how psychologists can be best supported to assist in the management of these symptoms. Further knowledge of effective coping strategies or stress management techniques within this population, either on a personal or organisational level is of importance (as also discussed in the paper by Rao et al., 2015).

Considering the findings within this review, it could be beneficial for certain individual and organisational strategies to be put in place in order to reduce stress levels and burnout in this population and increase coping mechanisms. On an individual level, the use of effective coping strategies to manage stress could be of benefit and considering being younger appears to place an individual at a higher risk of burnout, perhaps younger clinical psychologists could be prioritised. From an organisational perspective, monitoring stress and burnout would be the first step in order to intervene if necessary. In addition, allowing control within the role, attempting to reduce role conflict and ensuring the clinician has a range of cases rather than a diagnostically homogenous group of patients or a group that are particularly complex could help.

The development of validated stress and coping questionnaires tailored to psychologists would be of potential value. This would remove the potential bias created by psychologists completing the same measures that they use in clinical practice (as discussed in Sampson, 1989). There was attempt to develop a 'Mental Health Professional Stress Scale' (Cushway et al., 1996; Mehrotra, Rao, & Subbakrishna, 2000) as used in the included study by Rao and Mehrotra (1998), however, recent research has not utilised this measure. Alternative measures of stress, such as taking saliva samples to measure cortisol levels could provide further objective information about stress in this population (Amirkhan et al., 2015).

As noted previously, none of the included studies provided information about the individuals that were approached to partake in the research but decided not to. Walsh and Cormack (1994) conducted interviews with clinical psychologists about their use of support in the workplace and an emerging theme was the fear of being seen as unable to cope. It could be speculated that clinical psychologists who experience the greatest levels of stress might choose not to participate; hence, levels of psychological distress could be underestimated by these studies. Conversely, Goodwin et al.'s (2013) review suggests that reports of stress are usually higher in occupational studies rather than population studies; thus if an individual knows they have been approached due to their occupation group, they may inflate their levels of stress. It is suggested that this could be due to contextual factors; if the participant completes a measure in work, they could report their frustrations regarding their job more in the hope that this could affect change. Further exploration of this with this particular population would be beneficial.

It is important to highlight that stress is often defined as a negative outcome, however Selye (1993) did consider 'good stress', highlighting that stress can have a positive effect on productivity and wellbeing at work. Further research into the positive outcomes of stress in this population would be of interest. Considering PA was rated as high in this population, utilising a measure of job satisfaction could have provided more insight into the more positive aspects of the role.

Reliance upon cross-sectional methodology within these papers is a constraint; as

although this provides information at a given time point, changes that may occur in these relationships over time are not observed. It also does not allow for causal inferences to be made. Longitudinal follow up studies would allow for direct comparison between newly qualified psychologists and those with more experience by assessing the same participants over the course of their careers. The current review highlights the necessity for robust, generalisable research to be conducted with this population in order to draw firmer conclusions.

Strengths and limitations of this review

The use of unpublished dissertations as well as published articles is a strength of this review as it reduces the risk of the 'file drawer effect'; where studies that do not identify significant results are not published (Rosenthal, 1979). However, it should still be acknowledged that additional studies may still exist, but have not been published nor be part of a dissertation indexed within electronic databases. The inclusion of samples consisting solely of clinical psychologists is another strength of this review as it increases homogeneity across studies.

A limitation of the review is that a singular definition of burnout was used throughout. Further analysis into the reliability of burnout as a reliable construct, rather than being a different way of operationalising boredom or depression requires further attention.

A relative strength of this review is that it included studies from across the world. Although this allows for a better understanding of psychologists' experiences across countries, as Hannigan et al. (2004) recognised, direct comparison between the experiences of UK clinical psychologists and those in non-UK countries can be problematic due to variations in the organisation of healthcare provision and the role of the clinical psychologist.

A further aspect, which may be both a strength and limitation of the review is that it included studies that spanned four decades – although this allows inclusion of more information, the role of the psychologist may have changed over this period of time with a corresponding increase in responsibility. Examples of this include additional

roles in consultation, teaching and supervision, with perhaps less focus on direct therapeutic work (BPS, 2015). A further limitation is that this review only included papers published in the English language. Thus, relevant studies in other languages that fit in the inclusion/exclusion criteria may have been overlooked.

Conflict of interest declaration

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Systematic Review References

Ackerley, G. D., Burnell, J., Holder, D. C., & Kurdek, L. A. (1988). Burnout among licensed psychologists. *Professional Psychology: Research and Practice*, *19*, 624–631.

Ader, R. (1980). Psychosomatic and Psychoimmunologic research. *Psychosomatic Medicine*, *42*, 307–321.

Agency for Healthcare Research and Quality. (2002). *Systems to rate the strength of scientific evidence. Evidence Report/Technology Assessment: number 47*. Rockville, MD.

Amirkhan, J. H., Urizar Jr, G. G., & Clark, S. (2015). Criterion validation of a stress measure : The Stress Overload Scale. *Psychological Assessment*, *27*, 985–996.

Bartlett, D. (1998). *Stress: Perspective and processes*. University of Michigan: Open University Press.

Bianchi, R., Schonfeld, S. I., & Laurent, E. (2015). Burnout – depression overlap : A review. *Clinical Psychology Review*, *36*, 28–41.

Biggs, A., Brough, P., Drummond, S. (2017). Lazarus and Folkman's Psychological Stress and Coping Theory. In C. L. Cooper & J. Campbell Quick (Eds.), *The Handbook of Stress and Health: A guide to Research and Practise*. Chichester: John Wiley & Sons.

Blau, P. M. (1960). Orientation toward clients in a public welfare agency. *Administrative Science Quarterly*, *5*, 341–361.

Boakes, J. C. (1998). *Clinical Psychologists and Multi-disciplinary Teams: An investigation into team/professional identification, job satisfaction and burnout in clinical psychologists*. Unpublished manuscript, Salomons Canterbury Christ Church College.

Borritz, M., Rugulies, R., Christensen, K. B., Villadsen, E., & Kristensen, T. S. (2006). Burnout as a predictor of self-reported sickness absence among human service workers: prospective findings from three year follow up of the PUMA study. *Occupational and Environmental Medicine*, *63*, 98–107.

BPS. (2015). Clinical psychology in Britain: Historical perspectives. *HoPC, Monograph*. Leicester: British Psychological Society.

BPS. (2017). What is a Clinical Psychologist?

(https://careers.bps.org.uk/area/clinical): British Psychological Society.

Campagne, D. M. (2012). When therapists run out of steam: Professional boredom or burnout? *Revista de Psicopatologia Y Psicologia Clinica2*, *17*, 75–85.

Carver, C. S., Scheier, M. F., & Weintraub, J. K. (1989). Assessing coping strategies: A theoretically based approach. *Journal of Personality and Social Psychology, 56,* 267–283.

Chanofsky, S. (2008). *Burnout throughout the Lifespan*. Unpublished manuscript, Widener University.

Cohen, J. (1960). A coefficient of agreement for nominal scales. *Educational and Psychological Measurement*, *20*, 37–46.

Cohen, S., Kamarck, T., & Mermelstein, R. (1983). A global measure of perceived stress. *Journal of Health and Social Behavior*, *24*, 385–396.

Cohen's Laboratory for the Study of Stress, Immunity and Disease. (2017). Dr. Cohen's Scales: Perceived Stress Scale. (www.psy.cmu.edu/wscohen)

CRD. (2009). Systematic reviews: CRD's guidance for undertaking reviews in health care. *Centre for Reviews and Dissemination*.

Cushway, D. (1988). *Stress in clinical psychology trainees*. Unpublished manuscript, Birmingham University.

Cushway, D., & Tyler, P. (1996). Stress in clinical psychologists. *International Journal of Social Psychology*, *42*, 141–149.

Cushway, D., & Tyler, P. A. (1994). Stress and coping in clinical psychologists. *Stress Medicine*, *10*, 35–42.

Cushway, D., Tyler, P. A., & Nolan, P. (1996). Development of a stress scale for mental health professionals. *British Journal of Clinical Psychology*, *35*, 279–295.

D'Souza, F., Egan, S. J., & Rees, C. S. (2011). The relationship between perfectionism, stress and burnout in clinical psychologists. *Behaviour Change*, *28*, 17–28.

Darongkamas, J., Burton, M. V, & Cushway, D. (1994). The use of personal therapy by clinical psychologists working in the NHS in the United Kingdom. *Clinical Psychology and Psychotherapy*, *1*, 165–173.

Draper, B., Bowring, G., Thompson, C., Van Heyst, J., Conroy, P., & Thompson, J.

(2007). Stress in caregivers of aphasic stroke patients : a randomized controlled trial. *Clinical Rehabilitation*, *21*, 122–130.

Endler, N. S., & Parker, J. D. A. (1990). *Coping Inventory for Stressful Situations (CISS): Manual*. Toronto, ON, Canada: Multi-Health Systems.

European Agency for Safety and Health at Work. (2009). Occupational safety and health in figures: Stress at work—facts and figures. (https://osha.europa.eu/en/tools-and-publications/publications/reports/TE-81-08-478-EN-C_OSH_in_figures_stress_at_work/view)

Fernand-Seguin Research Centre. (2007). How to measure stress in humans? *Centre for Studies on Human Stress*.

Folkman, S., & Lazarus, R. S. (1980). An analysis of coping in a middle-aged community sample. *Journal of Health and Social Behavior*, *21*, 219–239.

Freudenberger, H. J. (1975). The staff burn-out syndrome in alternative institutions. *Psychotherapy: Theory, Research and Practice*, *12*, 73–82.

Glaser, R., & Kiecolt-Glaser, J. K. (2005). Stress-induced immune dysfunction: implications for health. *Nature Reviews*, *5*, 243–251.

Goldberg, D., & Hillier, V. (1979). A scaled version of the GHQ. *Psychological Medicine*, *9*, 139–145.

Goldstein, D. S., & Kopin, I. J. (2009). Evolution of concepts of stress, *10*, 109–120.

Goodwin, L., Ben-Zion, I., Fear, N. T., Hotopf, M., Stansfeld, S. A., & Wessely, S. (2013). Are Reports of Psychological Stress Higher in Occupational Studies ? A Systematic Review across Occupational and Population Based Studies. *PLOS ONE*, *8*, 1–22.

Hannigan, B., Edwards, D., & Burnard, P. (2004). Stress and stress management in clinical psychology : Findings from a systematic review. *Journal of Mental Health*, *13*, 235–245.

Harris, M. A., Cox, S. R., Brett, C. E., Deary, I. J., & MacLullich, A. M. (2017). Stress in childhood, adolescence and early adulthood and cortisol levels in older age. *The International Journal on the Biology of Stress*, *20*, 140–148.

Health and Safety Executive. (2004). *Working together to reduce stress at work: a guide for employees*. (http://www.hse.gov.uk/pubns/indg424.pdf)

Jenaro, C., Flores, N., & Arias, B. (2007). Burnout and coping in human service

practitioners. *Professional Psychology: Research and Practice*, *38*, 80–87.

Johnson, S., Cooper, C., Cartwright, S., Donald, I., Taylor, P., & Millet, C. (2005). The experience of work-related stress across occupations. *Journal of Managerial Psychology*, *20*, 178–187.

Kristensen, T. S., Borritz, M., Villadsen, E., & Chrisensen, K. B. (2005). The Copenhagen burnout inventory: A new tool for the assessment of burnout. *Work and Stress*, *19*, 192–207.

Lawrence, J., Ashford, K., & Dent, P. (2006). Gender differences in coping strategies of undergraduate students and their impact on self-esteem and attainment. *Active Learning in Higher Education, 7,* 273–281.

Lazarus, R., & Folkman, S. (1984). *Stress, appraisal and coping*. New York: Springer.

Lazarus, R. S. (1995). Psychological stress in the workplace. In *Occupational Stress: A Handbook*. London: Taylor & Francis.

Lim, N., Kim, E. K., Kim, H., Yang, E., & Lee, S. M. (2010). Individual and work-related factors influencing burnout of mental health professionals: A meta-analysis. *Journal of Employment Counseling*, *47*, 86–96.

Lovibond, S. H., & Lovibond, P. F. (1995). *Manual for the Depression Anxiety Stress Scales* (2nd ed.). Sydney Australia: The Psychology Foundation of Australia.

Martin-Johnson, K. (2016). *Gender and self-care behaviors in the burnout of mental health professionals*. Unpublished manuscript, Walden University.

Maslach, C., & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of Occupational Behaviour*, *2*, 99–113.

Maslach, C., & Jackson, S. E. (1986). *Maslach Burnout Inventory*. *Consulting Psychologists Press*. Palo Alto, CA.

McHugh, M. L. (2012). Interrater reliability: the kappa statistic. *Biochemia Medica*, *22*, 276–282.

McManus, I. C., Winder, B. C., & Gordon, D. (2002). The causal links between stress and burnout in a longitudinal study of UK doctors. *The Lancet*, *359*, 2089–2090.

Mehrotra, S., Rao, K., & Subbakrishna, D. K. (2000). Factor structure of the mental

health professionals stress scale (MHPSS) among clinical psychologists in India. *International Journal of Social Psychology*, *46*, 142–150.

MIND. (2015). MIND - What is stress? (https://www.mind.org.uk/information-support/tips-for-everyday-living/stress/#.WSGVVxiZNE4)

Moos, R. H., Cronkite, R. C., Billings, A. G., & Finney, J. W. (1984). *Health and Daily Living Form Manual*. Palo Alto, CA: Veterans Administration and Stanford University Medical Centers.

Morse, G., Salyers, M. P., & Pfahler, C. (2012). Burnout in mental health services: A review of the problem and its remediation. *Administration and Policy in Mental Health*, *39*, 341–352.

Murray, G. C. (1990). *Role Stress and Job Satisfaction in NHS Clinical Psychologists Working in Scotland*. Unpublished manuscript, University of Edinburgh.

NICE. (2009). Mental wellbeing at work. Retrieved from http://www.nice.org.uk

PRISMA Group. (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA statement. PLoS Med.

Rao, A. S., Bhutani, G., Dosanjh, N., Clarke, J., Hacker-Hughes, J., Easton, S., Van Laar, D., & Cohen-tovée, E. (2015). Psychological wellbeing and resilience: Resetting the balance. *British Psychological Society*, 1–11. (http://www.bps.org.uk/system/files/Public%20files/ar_v10_resetting_the_balance_160516.docx.pdf)

Rao, K., & Mehrotra, S. (1998). Clinical Psychologists in India: A time for reflection and action. *Indian Journal of Clinical Psychology*, *25*, 124–135.

Rosenthal, R. (1979). The file drawer problem and tolerance for null results. *Psychological Bulletin*, *86*, 638–641.

Rothenberger, D. A. (2017). Physician Burnout and well-being: A Systematic Review and framework for action. *Diseases of the Colon and Rectum*, *60*(6), 567–576.

Rupert, P. A., & Morgan, D. J. (2005). Work setting and burnout among professional psychologists. *Professional Psychology: Research and Practice*, *36*, 544–550.

Sampson, J. C. (1989). *Stress Survey of clinical psychologists in Scotland*. Unpublished manuscript, University of Edinburgh.

Schaufeli, W. B., Leiter, M. P., & Maslach, C. (2009). Burnout: 35 years of research and practice. *Career Development International*, *14*, 204–220.

Segerstrom, S. C., & Miller, G. E. (2004). Psychological stress and the human immune system : A Meta-Analytic study of 30 years of inquiry. *Psychological Bulletin*, *130*, 601–630.

Selye, H. (1936). A syndrome produced by Diverse Nocuous Agents. *Nature*, 32-32.

Selye, H. (1993). History and present status of the stress concept. In L. Goldberger & S. Breznitz (Eds.), *Handbook of stress* (2nd ed., pp. 7–17). New York: Free Press.

Shin, H., Park, Y. M., Ying, J. Y., Kim, B., Noh, H., & Lee, S. M. (2014). Relationships between coping strategies and burnout symptoms : A Meta-Analytic approach. *Professional Psychology: Research and Practice*, *45*, 44–56.

Shiralkar, M. T., Harris, T. B., Eddins-folensbee, F. F., & Coverdale, J. H. (2013). A Systematic Review of stress-management programs for medical students. *Academic Psychiatry*, *37*, 158–164.

Soares, J. J. F., & Grossi, G. (2007). Burnout among women: associations with demographic/ socio-economic, work, life-style and health factors. *Archives of Women's Mental Health*, *10*, 61–71.

Stevanovic, P., & Rupert, P. A. (2004). Career sustaining behaviours, satisfactions, and stresses of professional psychologists. *Psychotherapy: Theory, Research, Practice, Training, 3,* 301-309.

Sutherland, V. J., & Cooper, C. L. (1990). *Understanding Stress: a psychological perspective for health professionals*. London: Chapman and Hall.

Szabo, S. (1998). Hans Selye and the Development of the Stress Concept. *Annals of the New York Academy of Sciences*, *851*, 19–27.

The Joanna Briggs Institute. (2016). *The Joanna Briggs Institute Critical Appraisal tools for use in JBI Systematic Reviews: Checklist for Prevalence Studies*.

Vitaliano, P., Dewolfe, D., Maiuro, R., Russo, J., & Katon, W. (1990). Appraised changeability of a stressor as a modifier of the relationship between coping and depression: A test of the hypothesis of fit. *Journal of Personality and Social Psychology*, *59*, 582–592.

Volpe, U., Luciano, M., Palumbo, C., Sampogna, G., Del Vecchio, V., & Fiorillo, A.

(2014). Risk of burnout among early career mental health professionals. *Journal of Psychiatric and Mental Health Nursing*, *21*, 774–781.

Walsh, S., & Cormack, M. (1994). "Do as we say but not as we do": Organizational, professional and personal barriers to the receipt of support at work. *Clinical Psychology and Psychotherapy*, *1*, 101–110.

Wheeler, D, L., Vasser, M., Worley, J, A., & Barnes, L, L, B. (2011). A reliability generalization meta-analysis of coefficient alpha for the Maslach Burnout Inventory. *Educational and Psychological Measurement, 71,* 231-244.

Zapf, D. (2002). Emotion work and psychological well-being: A review of the literature and some conceptual considerations. *Human Resource Management Review*, *12*, 237–268.

Chapter 3: Empirical Research Journal Article

Working with People with Intellectual Disabilities and Behaviour that Challenges: Perspectives from Clinical Psychologists

Written in accordance with author guidelines for:

Journal of Applied Research in Intellectual Disabilities

(See Appendix D).

Abbreviated title for running head:

Perspectives of Clinical Psychologists in ID services

Keywords

Clinical psychology

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Challenging behaviour

Positive behaviour support

Thematic analysis

Empirical Study Abstract

Background: Although a considerable body of research has concentrated on the experience of paid carers and families involved with people with intellectual disabilities and behaviour that challenges, little is known about the experiences of professionals in multi-disciplinary healthcare teams, including clinical psychologists. This article explores their perspectives.

Method: Fourteen female clinical psychologists were interviewed. Thematic analysis was utilised to derive themes from their transcripts.

Results: Two overarching themes were apparent across all participants: difficult experiences and positive experiences. Participants reported barriers to influence change and feelings of stress, worry, anxiety, self-doubt and frustration within the role. Supervision and support from colleagues appeared to act as moderators of difficult emotions. All interviewees conveyed a sense of reward within their role.

Conclusions: Clinical psychologists incur varied experiences. It appears the benefit of support from colleagues is key in managing difficult emotions. Based on the findings, provisions that are believed to improve clinical psychologists' experiences are considered.

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Introduction

Approximately 10-15% of people with intellectual disabilities present with behaviour that challenges, with prevalence rising to 82% of people with profound intellectual and multiple disabilities (Emerson et al., 2001; Lowe et al., 2007; Poppes, Putten, & Vlaskamp, 2010). Behaviour that challenges has been defined as: "*Behaviour of such an intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion*." (Royal College of Psychiatrists/British Psychological Society/Royal College of Speech and Language Therapists, 2007, p. 14). These behaviours can include physical and/or verbal aggression, self-injurious behaviour, destruction of property, disruptive behaviour or sexually inappropriate behaviours and is seen as abnormal in the context of cultural norms (Emerson & Einfeld, 2011; Hastings, 2002a; National Institute for Health and Care Excellence; NICE, 2015).

The underlying reasons for these behaviours vary between individuals and may include: mental ill health, to communicate needs or distress, and/or to meet sensory needs. The origin and function of such behaviours is often complex (Cooper, Smiley, Morrison, Williamson, & Allan, 2007; Emerson & Einfeld, 2011). Behaviour that challenges has implications for both the individual with an intellectual disability and those that support them. For the former, this can include social exclusion, institutionalisation, deprivation, physical harm and abuse. People with intellectual disabilities and behaviour that challenges are often reliant on others for support, either paid carers or family members. Within this article, the term 'carers' is used to encompass both types of support (as per Emerson & Einfeld, 2011). For carers, adverse effects can include being at increased risk of physical and mental ill health and reduced quality of life (NICE, 2015).

Managing behaviour that challenges

The presence of behaviour that challenges often requires input from professionals external to the carers in order to promote safety and minimise the occurrence of the behaviour (RCP et al., 2007). In the UK, the NICE (2015, 2016) clinical guidelines

recommend that, every person with an intellectual disability receive an annual health check to assess both physical health and 'behavioural disturbance'. If behaviour that challenges is identified, either via an annual health check or other process, it is recommended that an assessment to ascertain the function of the behaviour is conducted, ideally using functional analysis (Beavers, Iwata, & Lerman, 2013). Once the function(s) have been identified, it is recommended that a behaviour support plan be written as soon as possible, based upon the individual's formulation.

These person-centred psychological approaches are often regarded as falling under the umbrella of Positive Behavioural Support (PBS; LaVigna & Willis, 2012) which stemmed from applied behavioural approaches. PBS is a multi-element model that focuses improving quality of life through understanding the function of the behaviour and emphasises building a repertoire of alternative behaviours to meet the same need (LaVigna & Willis, 2012) in addition to altering environmental factors. Dependent upon the assessment of the behaviour that challenges, medication could be considered, as there is evidence that this can be effective in some cases; however, it has been stipulated that medication should only be offered alongside psychological interventions (NICE, 2015).

As part of the PBS approach, carers play an integral role, in which they provide and gather information to aid assessment and formulation, and are fundamental in the implementation and monitoring of intervention guidelines (Allen, 1999; NICE, 2015). If used appropriately, PBS can be highly effective in reducing the frequency and severity of the behaviour that challenges, thereby improving the quality of life of individuals and those around them (LaVigna & Willis, 2012; NICE, 2015; RCP et al., 2007; The Scottish Government, 2014). These improvements have been observed in children (Harvey, Boer, Meyer, & Evans, 2009), adults with mild-moderate intellectual disability (Didden, Korzilius, van Oorsouw, & Sturmey, 2006) and adults with profound intellectual disabilities (Denis, Van den Noortgate, & Maes, 2011).

Ideally, PBS is implemented via a multi-disciplinary team (MDT) consisting of a variety of professionals including clinical psychologists, learning disability nurses, psychiatrists, occupational therapists, physiotherapists, speech and language therapists and social workers (Carr, O'Reilly, Noonan-Walsh, & McEvoy, 2007).

Often, the lead professional in this intervention is a clinical psychologist, and they are central to the assessment, development and implementation of the PBS approach (NICE, 2015).

Difficulties experienced by carers and healthcare professionals

When directly supporting an individual with an intellectual disability and behaviour that challenges (either as a paid carer or a relative) exposure to self-injurious behaviours or physical and verbal aggression is probable. Research indicates that this group of people experience significant levels of worry and stress (Baker et al., 2003; Baxter, Cummins, & Yiolitis, 2000; Griffith & Hastings, 2014; Hastings, 2002; Jenkins, Rose, & Lovell, 1997; Robertson et al., 2005). In addition, paid carers can experience symptoms of burnout such as emotional exhaustion and depersonalisation in their role (Blumenthal, Lavender, & Hewson, 1998; Gray-Stanley & Muramatsu, 2011; Hastings, 2002a). These experiences can reduce the quality of interactions with those they support (Hastings, 2002a; Rose, Jones, & Fletcher, 1998) and are associated with higher rates of staff turnover (Hatton et al., 2001).

However, not all research has found a direct link between stress and behaviour that challenges (e.g., Howard, Rose, & Levenson, 2009), instead other factors such as lack of resources and lack of support for paid carers (Hatton et al., 1999; Jenkins et al., 1997; Robertson et al., 2005; Thomas & Rose, 2010) and a lack of support/respite for families supporting their loved one at home (Griffith & Hastings, 2014) are associated with stress. Furthermore, other variables appear to have a moderating role of stress in carers. Firstly, self-efficacy, that is the belief in their ability to cope with the challenging situations they are faced with (Lazarus & Folkman, 1984) appears to be of importance. Research suggests that carers with confidence in their ability to respond to the behaviour appropriately appear to report lower levels of stress and burnout (Hastings & Brown, 2002a, 2002b; Hastings, 2002a; Howard et al., 2009).

Secondly, the beliefs, or attributions carers hold about the origin and cause of the behaviour has been highlighted as possibly significant (Hastings, 1995). Attribution

refers to the causal explanation of behaviour. Weiner's (1985) model considers controllability (does the individual have control over their behaviour) important in the influence of emotional responses such as anger and sympathy and the inclination to offer help (Weiner, 1985). Although some researchers have presented evidence to suggest there is a relationship between carer attributions and negative emotions (Chavira, Lopez, Blacher, & Shapiro, 2000; Wanless & Jahoda, 2002), others have found no such association (Bailey, Hare, Hatton, & Limb, 2006; Rose & Rose, 2005). A critical review reveals further inconsistencies when investigating the associations between attributions, emotions and the helping behaviour of carers (Willner & Smith, 2008).

When considering the wider support system involved in an individual's care, research with health and social care workers is lacking; in fact when reviewing the literature, no research was identified that assessed the impact upon workers involved with people with intellectual disabilities and behaviour that challenges. Nevertheless, research regarding healthcare workers in general suggested that they experience high levels of stress, anxiety and depression (Harris, Cumming, & Campbell, 2006; Health and Safety Executive, 2016) which may suggest those working in this field will have similar experiences.

Experiences of Psychologists

Prior reviews of the literature indicate that clinical psychologists experience stress within their role (Cushway & Tyler, 1994; Hannigan, Edwards, & Burnard, 2004). Since psychologists often play a lead role in assessment and intervention for behaviours that challenge, frequently working in a facilitative role (Willis & LaVigna, 1998) rather than directly with clients, this type of working may cause specific challenges. In addition, there is a general consensus in the literature that therapeutic change is slower in this population and advice from professionals, such as psychologists, is not always implemented consistently and as advised by carers (McKenzie, McLean, Megson, & Reid, 2005; The Scottish Government, 2014).

Study aims

Given the absence of research with clinical psychologists, who play a crucial role in the assessment and delivery of interventions in this area, the current study aimed to explore their experiences of working with individuals and carers of people with intellectual disabilities who present with behaviour that challenges. The perspectives gathered from these particular members of the MDT will increase our understanding of the challenges they face, give insight into ways of improving the service provided to clients and their carers, and possibly identify support mechanisms that clinical psychologists may personally require.

Methods

Methodology

A qualitative approach using thematic analysis (Braun & Clarke, 2006) was employed, with semi-structured interviews conducted in order to allow participants to share their experiences and to be able to explore topics introduced by participants (Braun & Clarke, 2013). Thematic analysis is suited to elucidating a group's experiences and viewpoints of a certain phenomenon (Braun & Clarke, 2013). Thematic analysis allows identification of common experiences across a group, and can be used to infer meaning from participants' responses whilst remaining as transparent, structured and systematic as possible (Joffe, 2012; Pistrang & Barker, 2012). It is believed that the use of thematic analysis as a methodology for this study will give sufficient flexibility to identify commonalities, as well as differences, in participants' experiences and perceptions (Braun & Clarke, 2006). Given the limited literature on this area, coupled with the potential complexity and breadth of experiences, quantitative methodology, which presupposes knowledge, was not deemed appropriate.

Alternative qualitative methodologies such as grounded theory and narrative approaches were considered. However, with regard to grounded theory, the aim was not to develop a theoretical framework but rather to identify the general themes that were common across experiences. Narrative approaches were deemed unsuitable due to the focus of the interviews being on the participant's job rather than their life as a whole (Barker, Pistrang, & Elliot, 2016). With regard to the use of qualitative methodology itself, thematic analysis allows for discovery and exploration of the participants' experiences, where quantitative approaches would not (Braun & Clarke, 2013).

Ethics

Ethical approval was granted from the University of Edinburgh School of Health in Social Science Ethics Committee (Reference no. AC16004). Approval to conduct the study was also obtained from the NHS Research and Development department of each Health Board where recruitment was undertaken (see Appendices E[i]-E[iv]).

Participants

Fourteen female qualified clinical psychologists who worked within NHS Scotland community learning disability MDTs participated in face-to-face interviews between March and August 2016. Participants worked within one of six Health Boards in NHS Scotland. A maximum of three participants from each Health Board were interviewed.

Age ranges were employed to reduce the risk of individual participants being identifiable. Seven described their ethnicity as White British, and seven as White Scottish. There was a broad range of length of experience, both pre- and post-qualification. This experience was solely with people with intellectual disabilities and behaviour that challenges. Considering the number of years experience has been seen to impact upon the stress and burnout levels in clinical psychologists (Cushway and Tyler, 1996), it is acknowledged that this variety within the sample could impact upon outcomes. Further work to explore this potential influence might be considered in the future. See Table 1 for participant demographic information.

Although not their sole role, all participants spent a significant proportion of their clinical time working with behaviour that challenges of a moderate-to-severe intensity. This was operationalised as: (i) behaviour that challenges exhibited at least once a day, (ii) the behaviour prevented participation in activities, (iii) the behaviour usually led to injury to either themselves or others (BPS, 2004). Four of the participants noted they had an active part-time role in a multi-disciplinary inpatient unit within their service. Psychologists that worked primarily in a forensic setting were excluded, as they primarily work with people that have presented with offending behaviour rather than behaviour that challenges (see Doyle, 2004, for a discussion of the distinction).

To note, only female clinical psychologists volunteered to partake; this is thought to reflect the increased incidence of females working in this field compared to males. In addition, prior research has indicated there are differences in stress levels and coping across male and female population in general (Matud, 2004) and amongst mental

health professionals (Cushway & Tyler, 1994). Considering these differences, having only female psychologists volunteer increased the homogeneity of the sample.

Variable	Range	Mean (SD)
Age	26-55	40.86 (6.42)
Number years experience pre-qualification	3-13	4.57 (3.92)
Number of years experience post-qualification	3-28	12.64 (7.2)

Table 1: Participant demographic information

Recruitment

Heads of NHS learning disability psychological services across Scotland were contacted and provided with information about the research. Once appropriate approvals in each respective Health Board had been gained, heads of psychological services were asked to disseminate the study information sheets to relevant and eligible staff within their service. Those interested then contacted the researcher to express interest, and they were given the opportunity to ask any further questions and to arrange a suitable date for consent to be taken in person, and the interview to be conducted.

Fourteen participants were considered an appropriate quantity as saturation (where no new themes or ideas are identified) for thematic analysis is usually reached around participant 12 (Guest, Bunce & Johnson 2006). Hence, it was considered that a target number of 14 would enable the identification of themes within this participant group.

Interviews

Prior to the interview, participants were provided with written information about the study and given the opportunity to ask any questions (see Appendix F). Participants were advised that their responses remained anonymous, and that they could withdraw at any point without consequence. Participants were made aware that confidentiality would be breached if there was concern around either their own or a colleagues' fitness to practice, or to the safety of a vulnerable adult or child. In such cases, relevant NHS processes to manage risk would be followed. Each participant completed a consent form and demographic questionnaire prior to interview (see Appendix G and H).

A semi-structured interview guide (see Appendix I) was used. The key areas covered were: theoretical approaches used and experiences of this, working with others (carers, other professionals), and personal impact of work. Interviews were carried out at participants' places of work. Interviews lasted between 26 and 90 minutes (M = 51.21 minutes, SD = 17.84). The primary researcher (ES) transcribed all interviews.

Data analysis

Thematic analysis was used to encode the data; Braun and Clarke's (2006) guidelines on the use of thematic analysis informed the analysis process. NVivo 11 qualitative data analysis software (QSR International Pty Ltd, 2014) was utilised as a tool in this process. The use of NVivo allowed for the transparent and systematic examination of the material and identification of themes (Joffe, 2012).

In line with Braun and Clarke's (2006, 2013) guidance, themes were analysed from a 'theoretical' approach, This means that research questions were taken into account when analysing the data, rather than utilising a more 'inductive' approach, which allows for a very open analysis of the data. Prior research was considered, such as the experience of carers working with this population (e.g. Griffith & Hastings, 2013). However, there was also flexibility, which enabled wider themes other than those originally envisioned, to emerge across participants. In addition, attention is paid to the fact that analysis was, in part, driven by the researcher's standpoint,

identity and disciplinary knowledge of being a trainee clinical psychologist with prior experience working with both the client and interviewee population.

As per Braun and Clarke (2006), the researcher transcribed the interviews and re-read the transcriptions to familiarise herself with the data. Initial codes, the basic elements of data that contained meaning regarding psychologists' experiences, were recorded across all transcriptions and supportive quotations were noted. Codes were then collated to create possible themes where appropriate. A themed transcript sample can be found in Appendix J. The theme only remained in the analysis if it was prevalent across a number of participants' transcripts. These were then reviewed to ensure heterogeneity across identified themes and an additional researcher checked these to ensure accuracy. In addition, a second researcher coded a proportion of the transcripts with any discrepancy between coders being discussed and agreement thereafter was reached.

'Member checking' (Braun & Clarke, 2013, p. 282) was conducted to determine whether there was a good fit between researcher interpretation and representation of experiences and the participants' individual understanding of their own experience. This is considered to increase the reliability of results and reduce bias (Braun & Clarke, 2013). Codes and themes generated from participant's individual transcripts were sent to the 11 interviewees that consented to this process. Of the 11, two responded with comments and there were no discrepancies between the researcher's interpretation and participants' views.

Results

Therapeutic approaches

Almost all interviewees reported that they utilised PBS as their chosen framework to approach this work. Most interviewees reported that they worked in teams where other MDT colleagues were PBS trained, and one interviewee worked in a service where fully trained nurses would often take the lead in such cases. Of those that did not report PBS as their main theoretical approach, they recounted the use of behavioural theory and a few mentioned that they would use cognitive-behavioural approaches at times with more able clients.

Identified themes

Across all participants, each described various aspects of their roles as both positive and difficult in nature; therefore a global theme of 'variability in the role' was identified with two overarching organising themes encompassing these disparate aspects. Within these, a number of basic themes were identified. It appeared some of the basic themes had a causal role whilst others functioned as moderators. Given the interconnecting nature of the themes, the use of a thematic network (See Figure 1) was thought most appropriate to communicate the information, as per Attride-Stirling (2001).

A theme was deemed worthy of inclusion if the construct was apparent in more than half of the participants' transcripts (Braun & Clarke, 2013). As detailed in Attride-Stirling (2001) a global theme is a super-ordinate theme that encompasses a construct that spans the entire dataset. An organising theme is a middle-order theme that organises the basic themes into clusters. A basic theme is the lowest-order theme that contributes towards the higher-order themes. As can be seen from the network, some basic themes have a causal effect on others; this indicates that this construct is contributory to the other that it is linked to. In addition, some themes transpired to moderate the severity of others, for example support from colleagues seemed to moderate the amount of frustration an individual experienced. Quotes are provided to illustrate the relationship the themes have to one another.

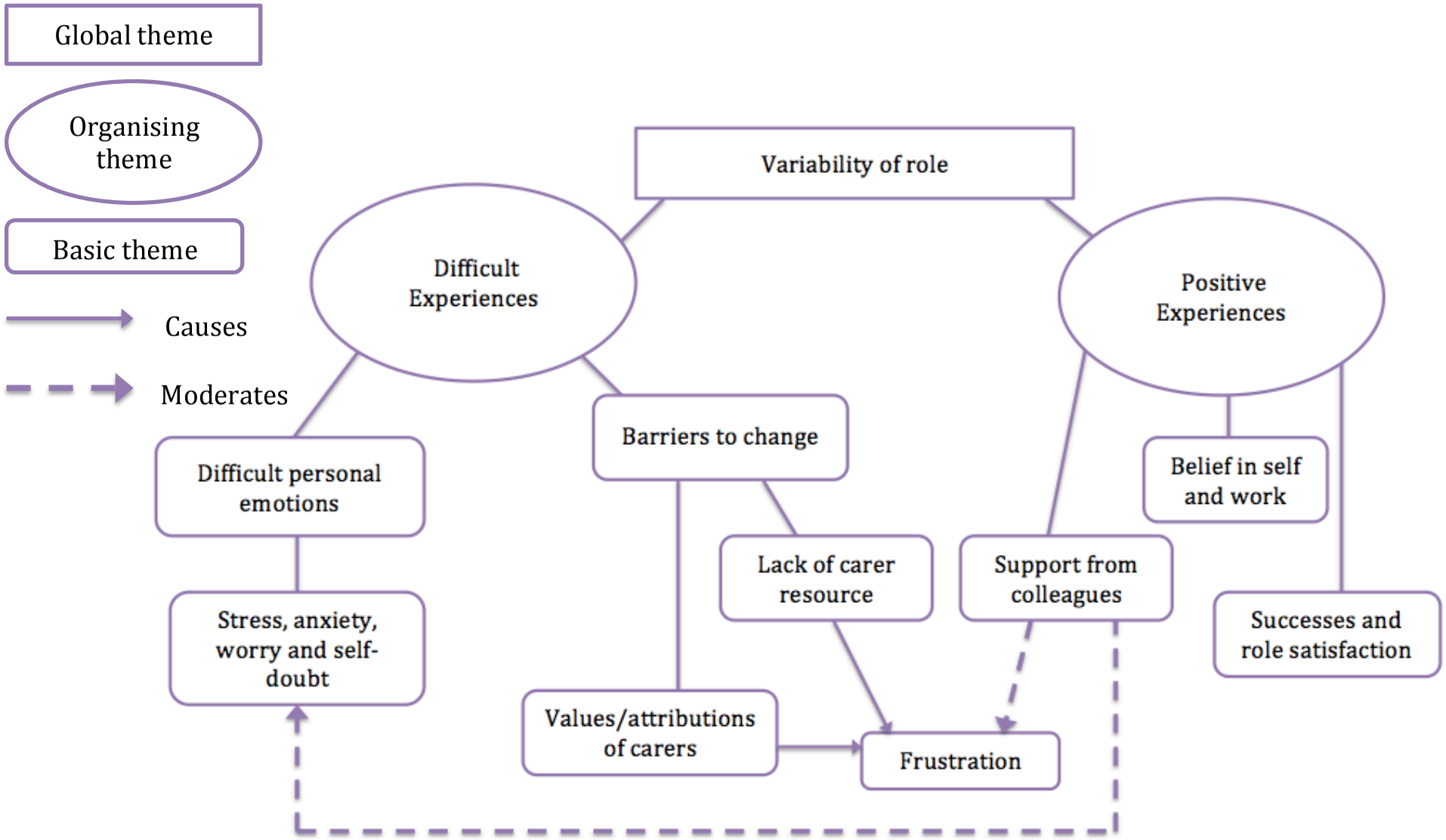

Figure 1: Thematic network (and key) representing themes derived from the data.

Global Theme: Variability of role

All interviewees talked about experiencing both positive and difficult situations and emotions, indicating variability within the role. None of the interviewees spoke exclusively about difficult experiences and none spoke exclusively about positive, it appeared to be a genuine combination of experience for all.

> *'I think it can be a rollercoaster, you have successful cases and you feel very empowered and… you work with other cases where there's no change at all'* (i3)

Furthermore, the carers the psychologists work with were described as diverse.

> *'It's variable, I think you have to see it as very much an individual circumstance… no two staff teams, no two inpatient staff teams, no two families, no two set of circumstances are the same. So you've got to just assess it as it presents'* (i9)

Organising Theme: Difficult experiences.

Difficult personal emotions: Stress, anxiety, worry and self-doubt.

Experiences of stress, anxiety, worry and self-doubt were commonly reported.

Stress

Interviewee three talked about her experience of stress when working directly with clients *'they can be stressful if they're unpredictable… or things seem to be quite stable and then something flares up out of the blue and having to manage that'* or more generally within the role;

> '*You'd have five or six [clients] just before you go on holiday… where for some reason they'd all get worse at once and that's extremely stressful'* (i2)

Anxiety

Interviewee 13 spoke about periods of anxiety when working directly with clients *'fearful if you're going to see somebody who has a reputation for being significantly*

physically aggressive' and Interviewee six explained *'I've had to pull my… alarm at times in places that I've worked so I have been… scared, terrified'*.

Worry

Many interviewees expressed worry about clients and concern around the level of support they have managed to provide when situations appeared risky.

> '*It's more about the concerns about if things are a bit precarious in a situation, or if somebody's having a difficult time. You're thinking about have you left them with enough resource, have you left them in a situation that could go horribly pear-shaped, are they going to be OK? Waking up at three o'clock in the morning white and sweating hoping that everything's alright when you go back in the morning'* (i14)

Self-doubt

With regard to their role, a few interviewees mentioned that being a clinical psychologist, can at times, lead others to have high expectations of their input and that this added an increased pressure.

> *'A common experience for a lot of qualified psychologists… is that there is this magic wand that you will wave and somehow you will fix the problem'* (i1)

It appeared as though the aforementioned difficult emotions, alongside the pressure from others, can lead to self-doubt for some. A number of psychologists conveyed this.

> *'I always think [challenging behaviour work is] one of the more complex things … and potentially one of those things that, you know, gets you that panic of incompetence (laughs) like I don't know what I'm doing'* (i7)

> *'Sometimes I'll get a referral and I'll read it and my initial thought is "oh dear I don't know what I'm going to do with that"… sometimes you get that heart sink feeling… especially if it's something that you've never heard of before and it looks like it's extremely challenging'* (i2)

Barriers to change:

The following sub-themes were discussed in the context of hindering successful assessment and intervention. Some explained that there was a dichotomy between

what they felt was needed regarding treatment and the action they were able to take subject to various constraints.

Values/attributions of carers

Paid carers

There was discussion regarding a differing personal value base to that of paid carers, and that this can be a barrier at times.

> *'Sometimes the…ideology or the guiding principles of a particular organisation or team can be a bit of a barrier… sometimes it does clash with where we would be coming from and the sort of theoretical ideas that we might be using'* (i10)

Furthermore, the majority of psychologists talked about the unhelpful attributions that paid carers can hold, where they believe the person's behaviour is within their control. Interviewee eight reflected on the views of some paid carers she has worked with: *'What are some of their attributions? [That the client is] doing it on purpose… they need to be punished… a sense of intent… they hurt that person on purpose'*. Moreover it was highlighted that this can make change more challenging.

> *'When you start to hit on negative attitudes about someone then that's not at all easy to work with and that's a huge issue that you have to try and redress'* (i5)

Families

Some of the interviewees talked about occasions when their value system had differed from that of families and how this could be difficult to manage at times.

> *'You have to be careful about using your own value base and judging others… the mother was a very… religious… person and personally I'm not and I don't have that same value base and that same… moral viewpoint so you know obviously… you're always aware of… not imposing your own values"* (i1)

Perhaps due to the unique relationship between family members, a number of interviewees went onto say that families can often remain stalled in the view of the individual as a child rather than an adult, which can impact upon progression.

'I think some families can be quite set in their ways and what they believed was best for the person when the person was young they still believe they haven't been able to move it forward at all' (i6)

Lack of carer resource

The majority of those interviewed expressed understanding towards the carers in terms of their resource, both on an organisational level for paid carers and a personal level for families.

Paid carers lack of organisational resource

With regard to a lack of funding across support services, Interviewee eight questioned *'can they actually deliver on... what you're asking them to do… is the money there, you know can they afford to take [him] to the café once a week?'*
The majority of interviewees spoke about the level of understanding the paid carers have being particularly important and that, at times the induction training prior to working with this population is deficient.

'I've actually had a look at some of the training programmes in autism, for example, and there is no way there is enough information for the staff to work with someone with autism, it's not detailed enough' (i2)

When characteristics of what made a 'good team' were reflected upon, the vast majority of psychologists talked about the importance of proficient, supportive, leadership and how this is often absent in services.

'I think leadership is key in my experience… you can have the most willing staff team in the world who are on board but [if] they're not supported from above or it's rubbished or it's sabotaged… if the leadership is not there to push anything through in terms of getting a change and sustaining a change that's problematic' (i8)

In addition, some reflected on the pressures of being a support worker, and empathised as they had previously worked in a similar role.

'The level of stress that they experience on a day to day basis is so high you know not many of us go to work with the real possibility that we can be physically harmed… or have even verbal insults that really undermine who

we think we are… I try and bring part of that to my job because in a previous life to being a psychologist that was my job and I remember those experiences very vividly' (i9)

Families' lack of personal resource

When families were discussed, almost all interviewees recognised that families have additional responsibilities, other than to care for their family member, and again expressed empathy toward these individuals and their capacity to fully engage with support.

'Unpaid carers are doing 101 other things, you know they're looking after the house, they've got other kids or they've got grandchildren or they still have a part time job… the demands on them are often huge' (i1)

'We have to remember is it's often 24/7… especially with challenging behaviour there's often a chronicity that we can't even comprehend' (i9)

Some psychologists acknowledged that families have an emotional connection/investment to their family member, which may impact upon their ability to engage.

'When you have an emotional… a familial bond to someone… it's harder to do what you know needs to be done sometimes because of that familial bond' (i8)

Considering this differentiation of focus on organisational resource for paid carers and personal resource for families, a few interviewees reflected that this can cause them to approach a familial situation slightly differently to a paid carer support system.

'I think I am more empathetic to the families and their difficulties… and what it would feel like to have external people so involved in your family life' (i11)

Frustration

It appears that both the values/attributions of carers and the lack of available resource could lead to frustration in those interviewed. Frustration, particularly toward paid carers and lack of change in those systems, was an experience cited by almost all

those interviewed. Interviewee five stated, *'I probably get frustrated with bits of the system and them not changing, not moving fast enough and I think urgh'.*

This sense of frustration, it seemed, often stemmed from a lack of progress, from carers not taking on board the recommendations.

> '*Staff teams that say yeah, yep, yeah, yes and then don't do it. I think if it's one team that drives me bonkers it's that so they say yes so all their verbals are going yeah, yeah, yeah, yeah, yeah, but all their behaviour is going no, no, no, no, no'* (i8)

Although fewer mentioned frustration toward family carers, the experience was still apparent.

> *'There's a family that I have worked with and… we've had trainees work with and another psychologist work with who have just have a very, very different view of what causes their… child's challenging behaviour and it has never shifted through all the work that all of us have done (long pause) and it feels like we just keep getting referrals back… and it's actually impossible to provide what they're asking for… and it just doesn't go anywhere'* (i11)

Organising Theme: Positive experiences

Support from colleagues

When the interviewees discussed strategies they used to manage their more difficult experiences and emotions, the majority of psychologists talked about the value of supervision and benefit of informal sharing of experiences with colleagues.

> *'Supervision, supervision… supervision is key… I think what I like about supervision… is both the time that is taken to recognise that personal impact but also to be thinking more practically, ok so how does this shape up in your work'* (i4)

> *'Going through things with somebody trying to, you know, "have I missed anything?" Where you're really concerned about something and doing that not only in supervision but with your teammates, your colleagues who are working with the person as well'* (i14)

It appeared that this support from colleagues acted as a moderator of difficult emotions such as stress, anxiety, worry, self-doubt and frustration.

'If I have worries about patients in terms of challenging behaviour or risk… then I'll sit down and speak to colleagues and try and reason it through so that I'm happy in my own head where I got to, which obviously then reduces any concern' (i12)

'[We] do supervision together and I think… there's a real strength of being able to take those frustrations and know somebody has an understanding of it, and I think that's probably the place where most of that emotion goes' (i13)

Belief in self and their work

Numerous participants talked positively about their professional identity, for example, Interviewee four remarked that *'it is a privileged position we're in… it's generally positive professionally and personally… to be in this field"*. A number of individuals talked about their role as a clinical psychologist being unique within the MDT.

'I have a belief that we can understand systems and that we've something unique to contribute… I don't think there are other professions that hold that, it's quite a unique perspective' (i9)

The majority of the interviewees mentioned feelings of hope and a sense of confidence in their ability.

'You do become more confident, you're able to look at a situation where things are difficult and think I can see how this can work out' (i13)

'I have a real belief that we can effect change' (i9)

In addition, there was a sense of belief in the model across participants, Interviewee five stated that *'I have to say within the unit … it's made an… enormous difference I see huge, huge benefits'* when referring to the use of PBS in an inpatient setting.

Successes and role satisfaction

Successes

Numerous interviewees reflected on the successes they have had in their role, with both paid carers and families.

'She was doing stuff that you would never have believed that she would've done… much better quality of life… more contact with her family as a result of it as well. It made a huge difference and there's… quite a few other tales like that' (i14)

Role satisfaction

All interviewees, at some point during their interview expressed an overall sense of reward and job satisfaction.

'I love it, I do, I absolutely love working with challenging behaviour and clients with challenging behaviour because it's just so nice, just a tiny wee thing like ohh, that's such and such out for a walk, we managed that as a team… I could talk for… days about how much of the positives I get' (i5)

'I find it fun, I find it stimulating… I'm smiling because I'm thinking about all the people I've worked with, I feel happy because… there's just this real feeling of satisfaction when you've… worked together as a team' (i8)

Discussion

This study aimed to explore clinical psychologists' experiences of working with people with intellectual disabilities and behaviour that challenges. It was evident that the majority of participants utilise PBS to some degree and take a lead role in these cases, as recommended in the NICE guidelines for this client group (NICE, 2015). As expected, it transpired that the role largely involves working via carers as facilitators, as mentioned in prior research (Willis & LaVigna, 1998) but that the work is not always consistently executed by carers (McKenzie et al., 2005) and that progress can be slow (The Scottish Government, 2014).

A global theme of variability was identified, with two organising themes comprising difficult experiences and positive experiences. Within these, basic themes were identified. Within difficult experiences, it was evident that there were some key perceived barriers to change including unhelpful values and attributions of carers and lack of carer resource. These factors appeared to lead to feelings of frustration in the interviewees. Psychologists also conveyed experiences of difficult personal emotions such as stress, anxiety, worry and self-doubt, just as paid carers and families have in the prior literature (Griffith & Hastings, 2014; Jenkins et al., 1997). These difficult emotions appeared to stem from both direct contact with the clients themselves and their behaviours that challenge, as well as the psychologist's ability to provide the support necessary to help the individual or their carers, particularly when risk increased. In relation to prior research that reported stress within the clinical psychology profession (Hannigan et al., 2004), it would appear that psychologists working with this population are no exception to symptoms of distress and stress.

The positive experiences theme contained successes and role satisfaction, belief in self and the work, and support from colleagues. Based upon the interviewees' viewpoints, they perceive that support from colleagues plays a moderator role to the more difficult emotions they experience in the role. This mirrors prior findings that suggested lack of support was linked to stress in paid carers (Hatton et al., 1999; Robertson et al., 2005) and family carers (Griffith & Hastings, 2014). It might have been conceivable that the other positive experiences such as successes, role

satisfaction and belief in self and the work, may play a moderator role for difficult experiences but this was not found to be the case.

Seemingly, there is a perceived disparity in experiences, with psychologists at times feeling as though they are confident in their abilities, expressing self-efficacy and at other times experiencing self-doubt. Considering almost all interviewees talked about experiences of stress, anxiety or worry at some point during their interview, being confident in one's ability does not seem to mean there is a lack of difficult emotion experienced. From this dataset it does not appear that a high level of self-efficacy and experiencing stress are mutually exclusive. Considering self-efficacy has been seen to impact upon carers ability to cope (Hastings & Brown, 2002a, 2002b; Howard et al., 2009); supporting psychologists to maintain a high level of self-efficacy may be of benefit. A review of the literature by Wheller and Richards (2007) suggested that supervision enhanced self-efficacy in therapists. Therefore, continued supportive work environments and regular supervision may benefit clinical psychologists working in this field. However, it is important to recognise that in both the general population and mental health professional coping literature, gender differences have been recognised, where women often experience higher levels of stress (Cushway & Tyler, 1996; Hannigan et al., 2004; Matud, 2004) and it appears that males appear to find it easier to emotionally detach from difficult experiences, whereas females seek others and engage in emotion-focused coping (Lawrence, Ashford, & Dent, 2006). Considering the participants within this study were all females, this may have biased the results in such direction.

It is notable that the experience of working with paid carers and families was portrayed slightly differently. Those interviewed appeared to have an increased level of empathy toward families compared to paid carers, and therefore expressed more frustration towards paid carers. It might be hypothesised that the psychologists hold particular attributions about paid carers and families, perhaps that paid carers are more in control of their behaviours and more able to influence change. Although it is unclear whether there is a direct link between attributions and negative emotions in carers (Willner & Smith, 2008), it could be stipulated that there is a link here.

Although it seems as though the psychologists were supported and satisfied within their organisation and MDT, the barriers to change were perceived to lie within the clients' environments and systems. It was reported that the lack of resources available to the paid carers included inadequate training, unhelpful attributions as well as a lack of leadership support within their system. Perhaps a thorough induction for the paid carers prior to working with this client group would help initially, with suitable leadership to further support the knowledge, understanding and confidence latterly. It might be posited that the experiences of carers may be moderated by better support structures within their systems/organisations. These additions might, in turn, provide the basis of a capable team for clinical psychologists to work with when working with individuals with intellectual disabilities and behaviour that challenges. Similarly, the views expressed by some participants; that many family carers continued to view their family member as child-like might indicate that initial work with families to assess their attributions around the maturity of their loved one and to formulate as appropriate might be of benefit.

The findings from this research could be viewed in relation to the job demands-resources model of burnout developed by Demerouti, Bakker, Nachreiner and Shaufeli (2001). They propose that negative experiences such as exhaustion and disengagement are an outcome of the job demands being too high and the job resources being limited. In line with this model, it would appear that the job demands such as the risks involved when working with this population and the pressure they experience from carers. This, alongside a lack of resource associated those they are working with (carers) and their dissonant attributions and values can lead to difficult experiences such as self-doubt and frustration. The model recognises the importance of supervisor support also, which again is mirrored in these findings.

Considering the perceived varied experiences that psychologists in this role have, continued organisational support mechanisms available for psychologists (supervision, management structure, MDT working) seems essential to maintain wellbeing and to moderate the effects of difficult experiences such as stress, self-

doubt and frustration. When reflecting on provisions to support these individuals, continuing to provide a supportive MDT with regular supervision appears to be of great benefit.

Normalising of the clinicians' experiences may be a key role in the support system, having an understanding that change is slower in this population and that it is normal for carers to not always follow advice and recommendations (McKenzie, McLean, Megson, & Reid, 2005; The Scottish Government, 2014). This may help the individual reduce pressure on themselves. In addition, allowing for monitoring of clinical psychologists' stress levels and mental wellbeing is key in order to ensure appropriate supports are put into place, whether this is at an individual level or an organisational level. For example, encouraging the use of self-care and a healthy work-life balance in these professionals may be of benefit on an individual level (Chanofsky, 2008). On a more organisational level, allowing the clinician to have control over their working week and how often they see clients their could help manage difficult emotions (Ackerley et al., 1988).

Strengths and limitations

The method utilised allowed the researcher to gain an understanding of the interviewees' perspectives, with face-to-face individual interviews viewed as being an appropriate way of gathering this information. The interviews allowed free expression of speech and the opportunity to elaborate upon various points. When considering the interview process, being aware that the interviewer was a trainee clinical psychologist is necessary. There are advantages to this method; the researcher had a basic knowledge of the area and the role of the interviewee and was therefore able to ask appropriate follow-on questions during interview. However, it may have meant that the qualified psychologists were less likely to discuss feelings of stress and self-doubt when talking to an individual that was still engaged in training, and therefore may have been viewed as their junior. They may have been keen to demonstrate to the interviewer that they utilised evidence-based practice in their work. This might have had an impact upon the interviewees' responses, and upon reflection it may have been interesting to ask their views on this post-interview.

According to Elliott, Fischer and Rennie's (1999) guidelines to evaluate qualitative research, every attempt has been made to consider the perspective of the researcher, the representativeness of the sample and the examples of themes presented to the reader. It is important to note that this type of methodology cannot, and does not attempt to remove subjectivity of the process entirely. Checking the themes derived from transcripts with participants and an additional researcher is a strength of this research as it reduced subjectivity of the researcher as much as is possible using this approach. Although the response rate for member checking was suboptimal, of those that did respond, there were no discrepancies. These attempted additional credibility checks allow the reader to deduce the reliability of the interpretation to some degree (Pistrang & Barker, 2012).

There is likely to have been a self-selection bias as those that participated volunteered to do so, perhaps indicating that those that took part were more interested in the subject, or were more confident in their skills and ability to reflect upon their work. However, this is purely speculation and it is therefore unknown. Considering the sample primarily utilised a widely recommended approach (PBS) and worked within community learning disability teams, which is the recommended and favoured system within the UK, these findings may be applicable across a wider area. As mentioned earlier, the entire sample were females, thus making the research outcomes inapplicable to males. Although firm conclusions and generalisations cannot be made, tentative inferences could be made across other female clinical psychologists and geographical locations within the UK.

Future research

Although the current sample was homogenous with regard to gender, it would be beneficial to ascertain whether males working in this area express any differing views to those expressed by the women interviewed. Considering the disparities in stress levels and coping strategies utilised by females and males, it would be of benefit to explore these differences further with this population.

In order to gain further insight into the levels of difficult emotions experienced, the causal mechanisms of this (possibly barriers to change, self-efficacy and attributions of carer behaviour) and the moderating impact of support (or other coping strategies) would provide a richer, deeper understanding of the relationship between these variables. Further information might provide knowledge about what could be done to improve the experience of these psychologists. Considering the clinical psychologists perceived barriers to change as characteristics of the carers and their situation, an interesting piece of research would be to obtain the views of carers that receive input from a clinical psychologist. Perhaps interviewing both individuals in the dyad would provide additional information about some of the perceived barriers to change from the carers' perspective.

Conclusions

Clinical psychologists who work with people with intellectual disabilities and behaviour that challenges each incur varied experiences within their role. Barriers to change were perceived to relate to carer attributions and lack of resource and this was perceived to lead to feelings of frustration. It appears the benefit of supervision and support from colleagues is key in managing difficult emotions. All conveyed a sense of reward from their role.

Conflict of interest declaration

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Empirical Study References

Ackerley, G. D., Burnell, J., Holder, D. C., & Kurdek, L. A. (1988). Burnout among licensed psychologists. *Professional Psychology: Research and Practice*, *19*, 624–631.

Allen, D. (1999). Mediator analysis: An overview of recent research on carers supporting people with intellectual disability and challenging behavior. *Journal of Intellectual Disability Research*, *43*, 325–339.

Attride-Stirling, J. (2001). Thematic networks: an analytic tool for qualitative research. *Qualitative Research*, *1*, 385–405.

Bailey, B. A., Hare, D. J., Hatton, C., & Limb, K. (2006). The response to challenging behaviour by care staff: emotional responses, attributions of cause and observations of practice. *Journal of Intellectual Disability Research*, *50*, 199–211.

Baker, B. L., Mcintyre, L. L., Blacher, J., Crnic, K., Edelbrock, C., & Low, C. (2003). Pre-school children with and without developmental delay: behaviour problems and parenting stress over time. *Journal of Intellectual Disability Research*, *47*, 217–230.

Barker, C., Pistrang, N., & Elliot, R. (2016). *Research methods in Clinical Psychology*. Chichester: John Wiley and Sons.

Baxter, C., Cummins, R. A., & Yiolitis, L. (2000). Parental stress attributed to family members with and without disability: A longitudinal study. *Journal of Intellectual and Developmental Disability*, *25*, 105–118.

Beavers, G. A., Iwata, B. A., & Lerman, D. C. (2013). Thirty years of research on the functional analysis of problem behavior. *Journal of Applied Behavior Analysis*., *46*, 1–21.

Blumenthal, S., Lavender, T., & Hewson, S. (1998). Role clarity, perception of the organization and burnout amongst support workers in residential homes for people with intellectual disability: a comparison between a National Health Service trust and a charitable company. *Journal of Intellectual Disability Research*, *42*, 409–417.

BPS. (2004). *Challenging Behaviour: Psychological interventions for severely challenging behaviours shown by people with learning disabilities*. Leicester:

British Psychological Society.

BPS. (2017). *Incorporating attachment theory into practice: Clinical practice guideline for clinical psychologists working with people who have intellectual disabilities*. Leicester: British Psychological Society.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*, 77–101.

Braun, V., & Clarke, V. (2013). *Successful Qualitative Research: a practical guide for beginners*. London: SAGE Publications.

Carr, A., O'Reilly, G., Noonan-Walsh, P., & McEvoy, J. (2007). *The handbook of Intellectual Diability and Clinical Psychology Practice*. Hove: Routledge.

Chanofsky, S. (2008). *Burnout throughout the Lifespan*. Unpublished manuscript, Widener University.

Chavira, V., Lopez, S. R., Blacher, J., & Shapiro, J. (2000). Latina mothers' attributions, emotions, and reactions to the problem behaviors of their children with developmental disabilities. *Journal of Child Psychology and Psychiatry*, *41*, 245–252.

Cooper, S., Smiley, E., Morrison, J., Williamson, A., & Allan, L. (2007). Mental ill-health in adults with intellectual disabilities : prevalence and associated factors. *British Journal of Psychiatry*, *190*, 27–35.

Cushway, D., & Tyler, P. (1996). Stress in clinical psychologists. *International Journal of Social Psychology*, *42*, 141–149.

Cushway, D., & Tyler, P. A. (1994). Stress and coping in clinical psychologists. *Stress Medicine*, *10*, 35–42.

Demerouti, E., Bakker, A. B., Nachreiner, F., & Shaufeli, W. B. (2001). The job demands-resources model of burnout. *Jounral of Applied Psychology, 86,* 499-512.

Denis, J., Van den Noortgate, W., & Maes, B. (2011). Self-injurious behavior in people with profound intellectual disabilities: A meta-analysis of single-case studies. *Research in Developmental Disabilities*, *32*, 911–923.

Didden, R., Korzilius, H., van Oorsouw, W., & Sturmey, P. (2006). Behavioral treatment of challenging behaviors in individuals with mild mental retardation: Meta-Analysis of single-subject research. *American Journal on Mental*

Retardation, *111*, 290–298.

Doyle, D. (2004). The differences between sex offending and challenging behaviour in people with an intellectual disability. *Journal of Intellectual and Developmental Disability*, *29*, 107 – 118.

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, *38*, 215–229.

Emerson, E., & Einfeld, S. (2011). *Challenging Behaviour* (3rd ed.). Cambridge: Cambridge University Press.

Emerson, E., Kiernan, C., Alborz, A., Reeves, D., Mason, H., Swarbrick, R., Mason, L., & Hatton, C. (2001). The prevalence of challenging behaviors : a total population study. *Research in Developmental Disabilities*, *22*, 77–93.

Gray-Stanley, J. A., & Muramatsu, N. (2011). Work stress, burnout, and social and personal resources among direct care workers. *Research in Developmental Disabilities*, *32*, 1065–1074.

Griffith, G., & Hastings, R. (2014). "He's hard work, but he's worth it". The experience of caregivers of individuals with intellectual disabilities and challenging behaviour: a meta-synthesis of qualitative research. *Journal of Applied Research in Intellectual Disabilities*., *27*, 401–19.

Guest, G. (2006). How many interviews are enough?: An experiment with data saturation and variability. *Field Methods*, *18*, 59–82.

Hannigan, B., Edwards, D., & Burnard, P. (2004). Stress and stress management in clinical psychology : Findings from a systematic review. *Journal of Mental Health*, *13*, 235–245.

Harris, L. M., Cumming, S. R., & Campbell, A. J. (2006). Stress and psychological well-being among Allied Health Professionals. *Journal of Allied Health*, *35*, 198–207.

Harvey, S. T., Boer, D., Meyer, L. H., & Evans, I. M. (2009). Updating a meta-analysis of intervention research with challenging behaviour : Treatment validity and standards of practice. *Journal of Intellectual and Developmental Disability*, *34*, 67–80.

Hastings, R. P. (1995). Understanding factors that influence staff responses to

challenging behaviours: an exploratory interview study. *Journal of Applied Research in Intellectual Disabilities*, *8*, 296–320.

Hastings, R. P. (2002a). Parental stress and behaviour problems of children with developmental disability. *Journal of Intellectual and Developmental Disability*, *27*, 149–160.

Hastings, R. P. (2002b). Do challenging behaviors affect staff psychological well-being? Issues of causality and mechanism. *American Journal of Mental Retardation*, *107*, 455–467.

Hastings, R. P., & Brown, T. (2002a). Behavior problems of children with autism, parental self-efficacy, and mental health. *American Journal on Mental Retardation*, *107*, 222–232.

Hastings, R. P., & Brown, T. (2002b). Behavioural knowledge, causal beliefs and self-efficacy as predictors of special educators' emotional reactions to challenging behaviours. *Journal of Intellectual Disability Research*, *46*, 144–150.

Hatton, C., Emerson, E., Rivers, M., Mason, H., Mason, L., Swarbrick, R., Kiernan, C., Reeves, D., & Alborz, A. (1999). Factors associated with staff stress and work satisfaction in services for people with intellectual disability. *Journal of Intellectual Disability Research*, *43*, 253–267.

Hatton, C., Emerson, E., Rivers, M., Mason, H., Swarbrick, R., Mason, L., Kiernan, C., Reeves, D., & Alborz, A. (2001). Factors associated with intended staff turnover and job search behaviour in services for people with intellectual disability. *Journal of Intellectual Disability Research*, *45*, 258–270.

Health and Safety Executive. (2016). *Work related stress, anxiety and depression statistics in Great Britain 2016*.

Howard, R., Rose, J., & Levenson, V. (2009). The psychological impact of violence on staff working with adults with Intellectual Disabilities. *Journal of Applied Research in Intellectual Disabilities*, *22*, 538–548.

Jenkins, R., Rose, J., & Lovell, C. (1997). Psychological well-being of staff working with people who have challenging behaviour. *Journal of Intellectual Disability Research*, *41*, 502–511.

Joffe, H. (2012). Thematic Analysis. In D. Harper & A. Thompson (Eds.),

Qualitative Research Methods in Mental Health and Psychotherapy: A guide for students and practitioners. (1st ed.). Chichester: John Wiley & Sons.

Ko, C., Lunsky, Y., Hensel, J., & Dewa, C. S. (2012). Burnout among summer camp staff supporting people with intellectual disability and aggression. *Intellectual and Developmental Disabilities*, *50*, 479–485.

LaVigna, G. W., & Willis, T. J. (2012). The efficacy of positive behavioural support with the most challenging behaviour: The evidence and its implications. *Journal of Intellectual and Developmental Disability*, *37*, 185–195.

Lawrence, J., Ashford, K., & Dent, P. (2006). Gender differences in coping strategies of undergraduate students and their impact on self-esteem and attainment. *Active Learning in Higher Education*, *7*, 273–281.

Lazarus, R., & Folkman, S. (1984). *Stress, appraisal and coping*. New York: Springer.

Lowe, K., Allen, D., Jones, E., Brophy, S., Moore, K., & James, W. (2007). Challenging behaviours : prevalence and topographies, *51*, 625–636.

Mace, C. F., Blum, N. J., Sierp, B. J., Delaney, B. A., & Mauk, J. E. (2001). Differential response of operant self-injury to pharmacologic versus behavioral treatment. *Developmental and Behavioral Pediatrics*, *22*, 85–91.

Matud, M, P. (2004). Gender differences in stress and coping styles. *Personality and Individual Differences*, *37*, 1401–1415.

McKenzie, K., McLean, H., Megson, P., & Reid, K. (2005). Behaviours that challenge. *Practice and Research*, *8*, 16-19.

NICE. (2015). Challenging Behaviour and Learning Disabilities: Prevention and interventions for people with learning disabilities whose behaviour challenges. (http://www.nice.org.uk)

NICE. (2016). Mental health problems in people with learning disabilities: Prevention, assessment and management. (http://www.nice.org.uk)

Pistrang, N., & Barker, C. (2012). Varieties of qualitative research: a pragmatic approach to selecting methods. In H. Cooper (Ed.), *APA Handbook of Research Methods in Psychology, Vol 2: Research Designs: Quantitative, Qualitative, Neuropsychological, and Biological*. (pp. 5–18). Washington, DC.

Poppes, P., Putten, A. J. J. Van Der, & Vlaskamp, C. (2010). Frequency and severity of challenging behaviour in people with profound intellectual and multiple

disabilities. *Research in Developmental Disabilities*, *31*, 1269–1275.

QSR International Pty Ltd. (2014). NVivo qualitative data analysis Software.

Royal College of Psychiatrists, British Psychological Society, Royal College of Speech and Language Therapists (2007). *Challenging behaviour: a unified approach (CR144). Royal College of Psychiatrists (http://www.rcpsych.ac.uk/les/pdfversion/cr144.pdf).*

Robertson, J., Hatton, C., Felce, D., Meek, A., Carr, D., Knapp, M., Hallam, A., Emerson, E., Pinkney., Caesar, E., & Lowe, K. (2005). Staff stress and morale in community-based settings for people with Intellectual Disabilities and challenging behaviour: A brief report. *Journal of Applied Research in Intellectual Disabilities*, *18*, 271–277.

Rose, D., & Rose, J. (2005). Staff in services for people with intellectual disabilities: the impact of stress on attributions of challenging behaviour. *Journal of Intellectual Disability Research*, *49*, 827–838.

Rose, J., Jones, F., & Fletcher, B. (1998). Investigating the relationship between stress and worker behaviour. *Journal of Intellectual Disability Research*, *42*, 163–172.

The Scottish Government. (2014). *The Matrix: People with Learning Disabilities. A Guide to Delivering Evidence-Based Psychological Therapies in Scotland. Edinburgh: NHS Education Scotland.*

Thomas, C., & Rose, J. (2010). The relationship between reciprocity and the emotional and behavioural responses of staff. *Journal of Applied Research in Intellectual Disabilities*, *23*, 167–178.

Wanless, L. K., & Jahoda, A. (2002). Responses of staff towards people with mild to moderate intellectual disability who behave aggressively: a cognitive emotional analysis. *Journal of Intellectual Disability Research*, *46*, 507–516.

Weiner, B. (1985). An attributional theory of achievement motivation and emotion. *Psychological Review*, *92*, 548–573.

Wheller, S., & Richards, K. (2007). The impact of clinical supervision on counsellors and therapists, their practice and their clients. A systematic review of the literature. *Counselling and Psychotherapy Research*, *7*, 54–65.

Willis, T. J., & LaVigna, G. W. (1998, January). Mediator Analysis. *Positive*

Practices (IABA Newsletter), p. 9–23.

Willner, P., & Smith, M. (2008). Attribution theory applied to helping behaviour towards people with Intellectual Disabilities who challenge. *Journal of Applied Research in Intellectual Disabilities*, *21*, 150–155.

Thesis Portfolio References

Ackerley, G. D., Burnell, J., Holder, D. C., & Kurdek, L. A. (1988). Burnout among licensed psychologists. *Professional Psychology: Research and Practice*, *19*, 624–631.

Ader, R. (1980). Psychosomatic and Psychoimmunologic research. *Psychosomatic Medicine*, *42*, 307–321.

Agency for Healthcare Research and Quality. (2002). *Systems to rate the strength of scientific evidence. Evidence Report/Technology Assessment: number 47*. Rockville, MD.

Allen, D. (1999). Mediator analysis: An overview of recent research on carers supporting people with intellectual disability and challenging behavior. *Journal of Intellectual Disability Research*, *43*, 325–339.

Amirkhan, J. H., Urizar Jr, G. G., & Clark, S. (2015). Criterion validation of a stress measure : The Stress Overload Scale. *Psychological Assessment*, *27*, 985–996.

Attride-Stirling, J. (2001). Thematic networks: an analytic tool for qualitative research. *Qualitative Research*, *1*, 385–405.

Bailey, B. A., Hare, D. J., Hatton, C., & Limb, K. (2006). The response to challenging behaviour by care staff: emotional responses, attributions of cause and observations of practice. *Journal of Intellectual Disability Research*, *50*, 199–211.

Baker, B. L., Mcintyre, L. L., Blacher, J., Crnic, K., Edelbrock, C., & Low, C. (2003). Pre-school children with and without developmental delay: behaviour problems and parenting stress over time. *Journal of Intellectual Disability Research*, *47*, 217–230.

Barker, C., Pistrang, N., & Elliot, R. (2016). *Research methods in Clinical Psychology*. Chichester: John Wiley and Sons.

Bartlett, D. (1998). *Stress: Perspective and processes*. University of Michigan: Open University Press.

Baxter, C., Cummins, R. A., & Yiolitis, L. (2000). Parental stress attributed to family members with and without disability: A longitudinal study. *Journal of Intellectual and Developmental Disability*, *25*, 105–118.

Beavers, G. A., Iwata, B. A., & Lerman, D. C. (2013). Thirty years of research on the

functional analysis of problem behavior. *Journal of Applied Behavior Analysis*., *46*, 1–21.

Bianchi, R., Schonfeld, S. I., & Laurent, E. (2015). Burnout – depression overlap : A review. *Clinical Psychology Review*, *36*, 28–41.

Biggs, A., Brough, P., Drummond, S. (2017). Lazarus and Folkman's Psychological Stress and Coping Theory. In C. L. Cooper & J. Campbell Quick (Eds.), *The Handbook of Stress and Health: A guide to Research and Practise*. Chichester: John Wiley & Sons.

Blau, P. M. (1960). Orientation toward clients in a public welfare agency. *Administrative Science Quarterly*, *5*, 341–361.

Blumenthal, S., Lavender, T., & Hewson, S. (1998). Role clarity, perception of the organization and burnout amongst support workers in residential homes for people with intellectual disability: a comparison between a National Health Service trust and a charitable company. *Journal of Intellectual Disability Research*, *42*, 409–417.

Boakes, J. C. (1998). *Clinical Psychologists and Multi-disciplinary Teams: An investigation into team/professional identification, job satisfaction and burnout in clinical psychologists*. Unpublished manuscript, Salomons Canterbury Christ Church College.

Borritz, M., Rugulies, R., Christensen, K. B., Villadsen, E., & Kristensen, T. S. (2006). Burnout as a predictor of self-reported sickness absence among human service workers: prospective findings from three year follow up of the PUMA study. *Occupational and Environmental Medicine*, *63*, 98–107.

BPS. (2004). *Challenging Behaviour: Psychological interventions for severely challenging behaviours shown by people with learning disabilities*. Leicester: British Psychological Society.

BPS. (2015). Clinical psychology in Britain: Historical perspectives. *HoPC*, *Monograph*. Leicester: British Psychological Society.

BPS. (2017). *Incorporating attachment theory into practice: Clinical practice guideline for clinical psychologists working with people who have intellectual disabilities*. Leicester: British Psychological Society.

BPS. (2017). What is a Clinical Psychologist?

(https://careers.bps.org.uk/area/clinical): British Psychological Society.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*, 77–101.

Braun, V., & Clarke, V. (2013). *Successful Qualitative Research: a practical guide for beginners*. London: SAGE Publications.

Campagne, D. M. (2012). When therapists run out of steam: Professional boredom or burnout? *Revista de Psicopatologia Y Psicologia Clinica2*, *17*, 75–85.

Carr, A., O'Reilly, G., Noonan-Walsh, P., & McEvoy, J. (2007). *The handbook of Intellectual Diability and Clinical Psychology Practice*. Hove: Routledge.

Carver, C. S., Scheier, M. F., & Weintraub, J. K. (1989). Assessing coping strategies: A theoretically based approach. *Journal of Personality and Social Psychology, 56,* 267–283.

Chanofsky, S. (2008). *Burnout throughout the Lifespan*. Unpublished manuscript, Widener University.

Chavira, V., Lopez, S. R., Blacher, J., & Shapiro, J. (2000). Latina mothers' attributions, emotions, and reactions to the problem behaviors of their children with developmental disabilities. *Journal of Child Psychology and Psychiatry*, *41*, 245–252.

Cohen, J. (1960). A coefficient of agreement for nominal scales. *Educational and Psychological Measurement*, *20*, 37–46.

Cohen, S., Kamarck, T., & Mermelstein, R. (1983). A global measure of perceived stress. *Journal of Health and Social Behavior*, *24*, 385–396.

Cohen's Laboratory for the Study of Stress, Immunity and Disease. (2017). Dr. Cohen's Scales: Perceived Stress Scale. (www.psy.cmu.edu/wscohen)

Cooper, S., Smiley, E., Morrison, J., Williamson, A., & Allan, L. (2007). Mental ill-health in adults with intellectual disabilities : prevalence and associated factors. *British Journal of Psychiatry*, *190*, 27–35.

CRD. (2009). Systematic reviews: CRD's guidance for undertaking reviews in health care. *Centre for Reviews and Dissemination*.

Cushway, D. (1988). *Stress in clinical psychology trainees*. Unpublished manuscript, Birmingham University.

Cushway, D., & Tyler, P. (1996). Stress in clinical psychologists. *International*

Journal of Social Psychology, *42*, 141–149.

Cushway, D., & Tyler, P. A. (1994). Stress and coping in clinical psychologists. *Stress Medicine*, *10*, 35–42.

Cushway, D., Tyler, P. A., & Nolan, P. (1996). Development of a stress scale for mental health professionals. *British Journal of Clinical Psychology*, *35*, 279–295.

Darongkamas, J., Burton, M. V, & Cushway, D. (1994). The use of personal therapy by clinical psychologists working in the NHS in the United Kingdom. *Clinical Psychology and Psychotherapy*, *1*, 165–173.

Demerouti, E., Bakker, A. B., Nachreiner, F., & Shaufeli, W. B. (2001). The job demands-resources model of burnout. *Jounral of Applied Psychology, 86,* 499-512.

Denis, J., Van den Noortgate, W., & Maes, B. (2011). Self-injurious behavior in people with profound intellectual disabilities: A meta-analysis of single-case studies. *Research in Developmental Disabilities*, *32*, 911–923.

Didden, R., Korzilius, H., van Oorsouw, W., & Sturmey, P. (2006). Behavioral treatment of challenging behaviors in individuals with mild mental retardation: Meta-Analysis of single-subject research. *American Journal on Mental Retardation*, *111*, 290–298.

Doyle, D. (2004). The differences between sex offending and challenging behaviour in people with an intellectual disability. *Journal of Intellectual and Developmental Disability*, *29*, 107 – 118.

Draper, B., Bowring, G., Thompson, C., Van Heyst, J., Conroy, P., & Thompson, J. (2007). Stress in caregivers of aphasic stroke patients : a randomized controlled trial. *Clinical Rehabilitation*, *21*, 122–130.

D'Souza, F., Egan, S. J., & Rees, C. S. (2011). The relationship between perfectionism, stress and burnout in clinical psychologists. *Behaviour Change*, *28*, 17–28.

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, *38*, 215–229.

Emerson, E., & Einfeld, S. (2011). *Challenging Behaviour* (3rd ed.). Cambridge:

Cambridge University Press.

Emerson, E., Kiernan, C., Alborz, A., Reeves, D., Mason, H., Swarbrick, R., Mason, L., & Hatton, C. (2001). The prevalence of challenging behaviors : a total population study. *Research in Developmental Disabilities*, *22*, 77–93.

Endler, N. S., & Parker, J. D. A. (1990). *Coping Inventory for Stressful Situations (CISS): Manual*. Toronto, ON, Canada: Multi-Health Systems.

European Agency for Safety and Health at Work. (2009). Occupational safety and health in figures: Stress at work—facts and figures. (https://osha.europa.eu/en/tools-and-publications/publications/reports/TE-81-08-478-EN-C_OSH_in_figures_stress_at_work/view)

Fernand-Seguin Research Centre. (2007). How to measure stress in humans? *Centre for Studies on Human Stress*.

Folkman, S., & Lazarus, R. S. (1980). An analysis of coping in a middle-aged community sample. *Journal of Health and Social Behavior*, *21*, 219–239.

Freudenberger, H. J. (1975). The staff burn-out syndrome in alternative institutions. *Psychotherapy: Theory, Research and Practice*, *12*, 73–82.

Glaser, R., & Kiecolt-Glaser, J. K. (2005). Stress-induced immune dysfunction: implications for health. *Nature Reviews*, *5*, 243–251.

Goldberg, D., & Hillier, V. (1979). A scaled version of the GHQ. *Psychological Medicine*, *9*, 139–145.

Goldstein, D. S., & Kopin, I. J. (2009). Evolution of concepts of stress, *10*, 109–120.

Goodwin, L., Ben-Zion, I., Fear, N. T., Hotopf, M., Stansfeld, S. A., & Wessely, S. (2013). Are Reports of Psychological Stress Higher in Occupational Studies ? A Systematic Review across Occupational and Population Based Studies. *PLOS ONE*, *8*, 1–22.

Gray-Stanley, J. A., & Muramatsu, N. (2011). Work stress, burnout, and social and personal resources among direct care workers. *Research in Developmental Disabilities*, *32*, 1065–1074.

Griffith, G., & Hastings, R. (2014). “He’s hard work, but he’s worth it”. The experience of caregivers of individuals with intellectual disabilities and challenging behaviour: a meta-synthesis of qualitative research. *Journal of Applied Research in Intellectual Disabilities*., *27*, 401–19.

Guest, G. (2006). How many interviews are enough?: An experiment with data saturation and variability. *Field Methods*, *18*, 59–82.

Hannigan, B., Edwards, D., & Burnard, P. (2004). Stress and stress management in clinical psychology : Findings from a systematic review. *Journal of Mental Health*, *13*, 235–245.

Harris, M. A., Cox, S. R., Brett, C. E., Deary, I. J., & MacLullich, A. M. (2017). Stress in childhood, adolescence and early adulthood and cortisol levels in older age. *The International Journal on the Biology of Stress*, *20*, 140–148.

Harris, L. M., Cumming, S. R., & Campbell, A. J. (2006). Stress and psychological well-being among Allied Health Professionals. *Journal of Allied Health*, *35*, 198–207.

Harvey, S. T., Boer, D., Meyer, L. H., & Evans, I. M. (2009). Updating a meta-analysis of intervention research with challenging behaviour : Treatment validity and standards of practice. *Journal of Intellectual and Developmental Disability*, *34*, 67–80.

Hastings, R. P. (1995). Understanding factors that influence staff responses to challenging behaviours: an exploratory interview study. *Journal of Applied Research in Intellectual Disabilities*, *8*, 296–320.

Hastings, R. P. (2002a). Parental stress and behaviour problems of children with developmental disability. *Journal of Intellectual and Developmental Disability*, *27*, 149–160.

Hastings, R. P. (2002b). Do challenging behaviors affect staff psychological well-being? Issues of causality and mechanism. *American Journal of Mental Retardation*, *107*, 455–467.

Hastings, R. P., & Brown, T. (2002a). Behavior problems of children with autism, parental self-efficacy, and mental health. *American Journal on Mental Retardation*, *107*, 222–232.

Hastings, R. P., & Brown, T. (2002b). Behavioural knowledge, causal beliefs and self-efficacy as predictors of special educators' emotional reactions to challenging behaviours. *Journal of Intellectual Disability Research*, *46*, 144–150.

Hatton, C., Emerson, E., Rivers, M., Mason, H., Mason, L., Swarbrick, R., Kiernan,

C., Reeves, D., & Alborz, A. (1999). Factors associated with staff stress and work satisfaction in services for people with intellectual disability. *Journal of Intellectual Disability Research*, *43*, 253–267.

Hatton, C., Emerson, E., Rivers, M., Mason, H., Swarbrick, R., Mason, L., Kiernan, C., Reeves, D., & Alborz, A. (2001). Factors associated with intended staff turnover and job search behaviour in services for people with intellectual disability. *Journal of Intellectual Disability Research*, *45*, 258–270.

Health and Safety Executive. (2004). *Working together to reduce stress at work: a guide for employees*. (http://www.hse.gov.uk/pubns/indg424.pdf)

Health and Safety Executive. (2016). *Work related stress, anxiety and depression statistics in Great Britain 2016*.

Howard, R., Rose, J., & Levenson, V. (2009). The psychological impact of violence on staff working with adults with Intellectual Disabilities. *Journal of Applied Research in Intellectual Disabilities*, *22*, 538–548.

Jenaro, C., Flores, N., & Arias, B. (2007). Burnout and coping in human service practitioners. *Professional Psychology: Research and Practice*, *38*, 80–87.

Jenkins, R., Rose, J., & Lovell, C. (1997). Psychological well-being of staff working with people who have challenging behaviour. *Journal of Intellectual Disability Research*, *41*, 502–511.

Joffe, H. (2012). Thematic Analysis. In D. Harper & A. Thompson (Eds.), *Qualitative Research Methods in Mental Health and Psychotherapy: A guide for students and practitioners*. (1st ed.). Chichester: John Wiley & Sons.

Johnson, S., Cooper, C., Cartwright, S., Donald, I., Taylor, P., & Millet, C. (2005). The experience of work-related stress across occupations. *Journal of Managerial Psychology*, *20*, 178–187.

Ko, C., Lunsky, Y., Hensel, J., & Dewa, C. S. (2012). Burnout among summer camp staff supporting people with intellectual disability and aggression. *Intellectual and Developmental Disabilities*, *50*, 479–485.

Kristensen, T. S., Borritz, M., Villadsen, E., & Chrisensen, K. B. (2005). The Copenhagen burnout inventory: A new tool for the assessment of burnout. *Work and Stress*, *19*, 192–207.

LaVigna, G. W., & Willis, T. J. (2012). The efficacy of positive behavioural support

with the most challenging behaviour: The evidence and its implications. *Journal of Intellectual and Developmental Disability*, *37*, 185–195.

Lawrence, J., Ashford, K., & Dent, P. (2006). Gender differences in coping strategies of undergraduate students and their impact on self-esteem and attainment. *Active Learning in Higher Education, 7*, 273–281.

Lazarus, R. S. (1995). Psychological stress in the workplace. In *Occupational Stress: A Handbook*. London: Taylor & Francis.

Lazarus, R., & Folkman, S. (1984). *Stress, appraisal and coping*. New York: Springer.

Lim, N., Kim, E. K., Kim, H., Yang, E., & Lee, S. M. (2010). Individual and work-related factors influencing burnout of mental health professionals: A meta-analysis. *Journal of Employment Counseling*, *47*, 86–96.

Lovibond, S. H., & Lovibond, P. F. (1995). *Manual for the Depression Anxiety Stress Scales* (2nd ed.). Sydney Australia: The Psychology Foundation of Australia.

Mace, C. F., Blum, N. J., Sierp, B. J., Delaney, B. A., & Mauk, J. E. (2001). Differential response of operant self-injury to pharmacologic versus behavioral treatment. *Developmental and Behavioral Pediatrics*, *22*, 85–91.

Martin-Johnson, K. (2016). *Gender and self-care behaviors in the burnout of mental health professionals*. Unpublished manuscript, Walden University.

Maslach, C., & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of Occupational Behaviour*, *2*, 99–113.

Maslach, C., & Jackson, S. E. (1986). *Maslach Burnout Inventory*. *Consulting Psychologists Press*. Palo Alto, CA.

Matud, M, P. (2004). Gender differences in stress and coping styles. *Personality and Individual Differences*, *37*, 1401–1415.

McHugh, M. L. (2012). Interrater reliability: the kappa statistic. *Biochemia Medica*, *22*, 276–282.

McKenzie, K., McLean, H., Megson, P., & Reid, K. (2005). Behaviours that challenge. *Practice and Research*, *8*, 16-19.

McManus, I. C., Winder, B. C., & Gordon, D. (2002). The causal links between stress and burnout in a longitudinal study of UK doctors. *The Lancet*, *359*, 2089–

2090.

Mehrotra, S., Rao, K., & Subbakrishna, D. K. (2000). Factor structure of the mental health professionals stress scale (MHPSS) among clinical psychologists in India. *International Journal of Social Psychology*, *46*, 142–150.

MIND. (2015). MIND - What is stress? (https://www.mind.org.uk/information-support/tips-for-everyday-living/stress/#.WSGVVxiZNE4)

Moos, R. H., Cronkite, R. C., Billings, A. G., & Finney, J. W. (1984). *Health and Daily Living Form Manual*. Palo Alto, CA: Veterans Administration and Stanford University Medical Centers.

Morse, G., Salyers, M. P., & Pfahler, C. (2012). Burnout in mental health services: A review of the problem and its remediation. *Administration and Policy in Mental Health*, *39*, 341–352.

Murray, G. C. (1990). *Role Stress and Job Satisfaction in NHS Clinical Psychologists Working in Scotland*. Unpublished manuscript, University of Edinburgh.

NICE. (2009). Mental wellbeing at work. Retrieved from http://www.nice.org.uk

NICE. (2015). Challenging Behaviour and Learning Disabilities: Prevention and interventions for people with learning disabilities whose behaviour challenges. (http://www.nice.org.uk)

NICE. (2016). Mental health problems in people with learning disabilities: Prevention, assessment and management. (http://www.nice.org.uk)

Pistrang, N., & Barker, C. (2012). Varieties of qualitative research: a pragmatic approach to selecting methods. In H. Cooper (Ed.), *APA Handbook of Research Methods in Psychology, Vol 2: Research Designs: Quantitative, Qualitative, Neuropsychological, and Biological*. (pp. 5–18). Washington, DC.

Poppes, P., Putten, A. J. J. Van Der, & Vlaskamp, C. (2010). Frequency and severity of challenging behaviour in people with profound intellectual and multiple disabilities. *Research in Developmental Disabilities*, *31*, 1269–1275.

PRISMA Group. (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA statement. PLoS Med.

QSR International Pty Ltd. (2014). NVivo qualitative data analysis Software.

Rao, A. S., Bhutani, G., Dosanjh, N., Clarke, J., Hacker-Hughes, J., Easton, S., Van Laar, D., & Cohen-tovée, E. (2015). Psychological wellbeing and resilience:

Resetting the balance. *British Psychological Society*, 1–11. (http://www.bps.org.uk/system/files/Public%20files/ar_v10_resetting_the_balance_160516.docx.pdf)

Rao, K., & Mehrotra, S. (1998). Clinical Psychologists in India: A time for reflection and action. *Indian Journal of Clinical Psychology*, *25*, 124–135.

Rosenthal, R. (1979). The file drawer problem and tolerance for null results. *Psychological Bulletin*, *86*, 638–641.

Rothenberger, D. A. (2017). Physician Burnout and well-being: A Systematic Review and framework for action. *Diseases of the Colon and Rectum*, *60*(6), 567–576.

Royal College of Psychiatrists, British Psychological Society, Royal College of Speech and Language Therapists (2007). *Challenging behaviour: a unified approach (CR144). Royal College of Psychiatrists (http://www.rcpsych.ac.uk/les/pdfversion/cr144.pdf).*

Robertson, J., Hatton, C., Felce, D., Meek, A., Carr, D., Knapp, M., Hallam, A., Emerson, E., Pinkney., Caesar, E., & Lowe, K. (2005). Staff stress and morale in community-based settings for people with Intellectual Disabilities and challenging behaviour: A brief report. *Journal of Applied Research in Intellectual Disabilities*, *18*, 271–277.

Rose, D., & Rose, J. (2005). Staff in services for people with intellectual disabilities: the impact of stress on attributions of challenging behaviour. *Journal of Intellectual Disability Research*, *49*, 827–838.

Rose, J., Jones, F., & Fletcher, B. (1998). Investigating the relationship between stress and worker behaviour. *Journal of Intellectual Disability Research*, *42*, 163–172.

Rupert, P. A., & Morgan, D. J. (2005). Work setting and burnout among professional psychologists. *Professional Psychology: Research and Practice*, *36*, 544–550.

Sampson, J. C. (1989). *Stress Survey of clinical psychologists in Scotland*. Unpublished manuscript, University of Edinburgh.

Schaufeli, W. B., Leiter, M. P., & Maslach, C. (2009). Burnout: 35 years of research and practice. *Career Development International*, *14*, 204–220.

Segerstrom, S. C., & Miller, G. E. (2004). Psychological stress and the human

immune system : A Meta-Analytic study of 30 years of inquiry. *Psychological Bulletin*, *130*, 601–630.

Selye, H. (1936). A syndrome produced by Diverse Nocuous Agents. *Nature*, 32-32.

Selye, H. (1993). History and present status of the stress concept. In L. Goldberger & S. Breznitz (Eds.), *Handbook of stress* (2nd ed., pp. 7–17). New York: Free Press.

Shin, H., Park, Y. M., Ying, J. Y., Kim, B., Noh, H., & Lee, S. M. (2014). Relationships between coping strategies and burnout symptoms : A Meta-Analytic approach. *Professional Psychology: Research and Practice*, *45*, 44–56.

Shiralkar, M. T., Harris, T. B., Eddins-folensbee, F. F., & Coverdale, J. H. (2013). A Systematic Review of stress-management programs for medical students. *Academic Psychiatry*, *37*, 158–164.

Soares, J. J. F., & Grossi, G. (2007). Burnout among women: associations with demographic/ socio-economic, work, life-style and health factors. *Archives of Women's Mental Health*, *10*, 61–71.

Stevanovic, P., & Rupert, P. A. (2004). Career sustaining behaviours, satisfactions, and stresses of professional psychologists. *Psychotherapy: Theory, Research, Practice, Training, 3,* 301-309.

Sutherland, V. J., & Cooper, C. L. (1990). *Understanding Stress: a psychological perspective for health professionals*. London: Chapman and Hall.

Szabo, S. (1998). Hans Selye and the Development of the Stress Concept. *Annals of the New York Academy of Sciences*, *851*, 19–27.

The Joanna Briggs Institute. (2016). *The Joanna Briggs Institute Critical Appraisal tools for use in JBI Systematic Reviews: Checklist for Prevalence Studies*.

The Scottish Government. (2014). *The Matrix: People with Learning Disabilities. A Guide to Delivering Evidence-Based Psychological Therapies in Scotland. Edinburgh: NHS Education Scotland*.

Thomas, C., & Rose, J. (2010). The relationship between reciprocity and the emotional and behavioural responses of staff. *Journal of Applied Research in Intellectual Disabilities*, *23*, 167–178.

Vitaliano, P., Dewolfe, D., Maiuro, R., Russo, J., & Katon, W. (1990). Appraised changeability of a stressor as a modifier of the relationship between coping and

depression: A test of the hypothesis of fit. *Journal of Personality and Social Psychology*, *59*, 582–592.

Volpe, U., Luciano, M., Palumbo, C., Sampogna, G., Del Vecchio, V., & Fiorillo, A. (2014). Risk of burnout among early career mental health professionals. *Journal of Psychiatric and Mental Health Nursing*, *21*, 774–781.

Wanless, L. K., & Jahoda, A. (2002). Responses of staff towards people with mild to moderate intellectual disability who behave aggressively: a cognitive emotional analysis. *Journal of Intellectual Disability Research*, *46*, 507–516.

Weiner, B. (1985). An attributional theory of achievement motivation and emotion. *Psychological Review*, *92*, 548–573.

Wheller, S., & Richards, K. (2007). The impact of clinical supervision on counsellors and therapists, their practice and their clients. A systematic review of the literature. *Counselling and Psychotherapy Research*, *7*, 54–65.

Willis, T. J., & LaVigna, G. W. (1998, January). Mediator Analysis. *Positive Practices (IABA Newsletter)*, p. 9–23.

Willner, P., & Smith, M. (2008). Attribution theory applied to helping behaviour towards people with Intellectual Disabilities who challenge. *Journal of Applied Research in Intellectual Disabilities*, *21*, 150–155.

Walsh, S., & Cormack, M. (1994). "Do as we say but not as we do": Organizational, professional and personal barriers to the receipt of support at work. *Clinical Psychology and Psychotherapy*, *1*, 101–110.

Wheeler, D, L., Vasser, M., Worley, J, A., & Barnes, L, L, B. (2011). A reliability generalization meta-analysis of coefficient alpha for the Maslach Burnout Inventory. *Educational and Psychological Measurement, 71,* 231-244.

Zapf, D. (2002). Emotion work and psychological well-being: A review of the literature and some conceptual considerations. *Human Resource Management Review*, *12*, 237–268.

Appendices

Appendix A – Systematic Review: Author guidelines for Clinical Psychology and Psychotherapy

MANUSCRIPT SUBMISSION

Clinical Psychology & Psychotherapy operates an online submission and peer review system that allows authors to submit articles online and track their progress via a web interface. Please read the remainder of these instructions to authors and then visit http://mc.manuscriptcentral.com/cpp and navigate to the *Clinical Psychology & Psychotherapy* online submission site.

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- Non-LaTeX users. Upload your manuscript files. At this stage, further source files do not need to be uploaded.
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- LaTeX users. When submitting your revision you must still upload a single .pdf that you have generated from your revised source files. You must use the File Designation "Main Document" from the dropdown box. In addition you must upload your TeX source files. For all your source files you must use the File Designation "Supplemental Material not for review". Previous versions of

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The language of the journal is English. 12-point type in one of the standard fonts: Times, Helvetica, or Courier is preferred. It is not necessary to double-line space your manuscript. Tables must be on separate pages after the reference list, and not be incorporated into the main text. Figures should be uploaded as separate figure files.

- During the submission process you must enter the full title, short title of up to 70 characters and names and affiliations of all authors. Give the full address, including email, telephone and fax, of the author who is to check the proofs.
- Include the name(s) of any **sponsor(s)** of the research contained in the paper, along with **grant number(s)** .
- Enter an **abstract** of up to 250 words for all articles [except book reviews]. An abstract is a concise summary of the whole paper, not just the conclusions, and is understandable without reference to the rest of the paper. It should contain no citation to other published work.
- All articles should include a **Key Practitioner Message** — 3-5 bullet points summarizing the relevance of the article to practice.
- Include up to six **keywords** that describe your paper for indexing purposes.

Types of Articles

- **Research Articles:** Substantial articles making a significant theoretical or empirical contribution.
- **Reviews**: Articles providing comprehensive reviews or meta-analyses with an emphasis on clinically relevant studies.
- **Assessments:** Articles reporting useful information and data about new or existing measures.
- **Practitioner Reports:** Shorter articles (a maximum of 1200 words) that typically contain interesting clinical material. These should use (validated) quantitative measures and add substantially to the literature (i.e. be innovative).

Title and Abstract Optimisation Information. As more research is read online, the electronic version of articles becomes ever more important. In a move to improve search engine rankings for individual articles and increase readership and future citations to Clinical Psychology & Psychotherapy at the same time please visit **Optimizing Your Abstract for Search Engines** for guidelines on the preparation of keywords and descriptive titles.

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REFERENCE STYLE

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   Example: Charlotte and Emily Bronte were polar opposites, not only in their personalities but in their sources of inspiration for writing (Taylor, 1990). Use the last name only in both first and subsequent citations, except when there is more than one author with the same last name. In that case, use the last name and the first initial.
2. **If the author is named in the text, only the year is cited** .
   Example: According to Irene Taylor (1990), the personalities of Charlotte. .
3. **If both the name of the author and the date are used in the text, parenthetical reference is not necessary.**
   Example: In a 1989 article, Gould explains Darwin's most successful. . .
4. **Specific citations of pages or chapters follow the year** .
   Example: Emily Bronte "expressed increasing hostility for the world of human relationships, whether sexual or social" (Taylor, 1988, p. 11).
5. **When the reference is to a work by two authors, cite both names each time the reference appears** .
   Example: Sexual-selection theory often has been used to explore patters of various insect matings (Alcock & Thornhill, 1983) . . . Alcock and Thornhill (1983) also demonstrate. . .
6. **When the reference is to a work by three to five authors, cite all the authors the first time the reference appears. In a subsequent reference, use the first author's last name followed by *et al* . (meaning "and others")** .
   Example: Patterns of byzantine intrigue have long plagued the internal politics of community college administration in Texas (Douglas *et al* ., 1997) When the reference is to a work by six or more authors, use only the first author's name followed by *et al* . in the first and all subsequent references. The only exceptions to this rule are when some confusion might result because of similar names or the same author being cited. In that case, cite enough authors so that the distinction is clear.
7. **When the reference is to a work by a corporate author, use the name of the organization as the author**.
   Example: Retired officers retain access to all of the university's educational and recreational facilities (Columbia University, 1987, p. 54).
8. **Personal letters, telephone calls, and other material that cannot be retrieved are not listed in References but are cited in the text** .

Example: Jesse Moore (telephone conversation, April 17, 1989) confirmed that the ideas. . .

9. **Parenthetical references may mention more than one work, particularly when ideas have been summarized after drawing from several sources. Multiple citations should be arranged as follows** .
   Examples:
   - List two or more works by the same author in order of the date of publication: (Gould, 1987, 1989)
   - Differentiate works by the same author and with the same publication date by adding an identifying letter to each date: (Bloom, 1987a, 1987b)
   - List works by different authors in alphabetical order by last name, and use semicolons to separate the references: (Gould, 1989; Smith, 1983; Tutwiler, 1989).

Reference List

APA – American Psychological Association

References should be prepared according to the Publication Manual of the American Psychological Association (6th edition). This means in text citations should follow the author-date method whereby the author's last name and the year of publication for the source should appear in the text, for example, (Jones, 1998). The complete reference list should appear alphabetically by name at the end of the paper.

A sample of the most common entries in reference lists appears below. Please note that a DOI should be provided for all references where available. For more information about APA referencing style, please refer to the APA FAQ. Please note that for journal articles issue numbers are not included unless each in the volume begins with page one.

Journal article

Beers, S. R. , & De Bellis, M. D. (2002). Neuropsychological function in children with maltreatment-related posttraumatic stress disorder. *The American Journal of Psychiatry*, *159*, 483–486. doi:10.1176/appi.ajp.159.3.483.

Book edition

Bradley-Johnson, S. (1994). Psychoeducational assessment of students who are visually impaired or blind: Infancy through high school (2nd ed.). Austin, TX: Pro-ed.

*The Digital Object Identifier (DOI) is an identification system for intellectual property in the digital environment. Developed by the International DOI Foundation on behalf of the publishing industry, its goals are to provide a framework for managing intellectual content, link customers with publishers, facilitate electronic commerce, and enable automated copyright management.

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- Personalization Tools

Cite EarlyView articles. To link to an article from the author's homepage, take the DOI (digital object identifier) and append it to "http://dx.doi.org/" as per following example: DOI 10.1002/hep.20941, becomes http://dx.doi.org/10.1002/hep.20941.

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- Creative Commons Attribution License OAA
- Creative Commons Attribution Non-Commercial License OAA
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Submission of a manuscript will be held to imply that it contains original unpublished work and is not being submitted for publication elsewhere at the same time.

Appendix B – Systematic Review: References of studies that were excluded during screening process

	Reference	Reason for exclusion
1	Ayala, E. (2015). *Does self-care moderate the relation of stress to quality of life of female doctoral students in professional psychology?* (Unpublished doctoral thesis). State University of New York, NY.	Participants not solely Clinical Psychologists
2	Bahrer-Kohler, S. (2013). Burnout for experts: Prevention in the context of living and working. Switzerland, Springer.	Not empirical research (e.g. book chapter)
3	Berger, S. R. (2011). *Challenging client behaviors, coping and burnout among professional psychologists*. (Unpublished doctoral thesis). Loyola University Chicago, IL.	Participants not solely Clinical Psychologists
4	Betan, E. J. (1996). *Understanding the ethical behaviour of clinical psychologists: Incorporating affect into the model of ethical decision making*. (Unpublished doctoral thesis). University of Kansas, KS.	No direct measure of stress/burnout/coping
5	Birdsong, E. A. (1993). *The Psychologist's experience of client suicide*. (Unpublished doctoral thesis). The Union Institute, OH.	Qualitative research
6	Boice, R., & Myers, P. E. (1987). Which setting is healthier and happier, academe or private practice? *Professional Psychology: Research and Practice*. 18(5), 526-529.	No direct measure of stress/burnout/coping
7	Briggs, D. B., & Munley, P. H. (2008). Therapist stress, coping, career sustaining behaviour and the working alliance. *Psychological Reports*. 103, 443-454.	Participants not solely Clinical Psychologists
8	Britt, D. E. (1997). *Psychotherapist Self-care*. (Unpublished doctoral thesis). The Pennsylvania State University, PA.	Participants not solely Clinical Psychologists
9	Brooks, J., Holttum, S., & Lavender, A. (2002). Personality style, psychological adaptation and expectations of trainee clinical psychologists. *Clinical Psychology and Psychotherapy*. 9, 253-270.	Focus of research was trainee Clinical Psychologists
10	Bucknall, A., & Unsworth, S. (1996). Frequency of client death and impact on clinical psychologists: a pilot study. *Clinical Psychology Forum*. 98, 34-38.	Qualitative research
11	Burgess, S., Rhodes, P., & Wilson, V. (2013). Exploring the in-session reflective capacity of	No direct measure of stress/burnout/coping

	clinical psychology trainees: An interpersonal process recall study. *Clinical Psychologist*. 17, 122-130.	
12	Charlemagne-Odle, S., Harmon, G., & Maltby, M. (2014). Clinical Psychologists' experience of personal significant distress. *Psychology and Psychotherapy: Theory, Research and Practice*. 87, 237-252.	Qualitative research
13	Coster, J. S., & Schwebel, M. (1997). Well-functioning in professional psychologists. *Professional Psychology: Research and Practice*. 28(1), 5-13.	Participants not solely Clinical Psychologists
14	Croke, M. (2016). *Burnout and compassion satisfaction among mental health clinicians*. (Unpublished doctoral thesis). William James College, MA.	Participants not solely Clinical Psychologists
15	Crowley, A., & Avdi, E. (1999). The impact of complex cases in an adult mental health specialty. *Clinical Psychology Forum*. 130, 13-17	No direct measure of stress/burnout/coping
16	Cushway, D., Tyler, P. A., & Nolan, P. (1996). Development of a stress scale for mental health professionals. *British Journal of Clinical Psychology*. 35, 279-295.	Participants not solely Clinical Psychologists
17	Daniel-Washington, C. (2011). *Distress, rewards, and strategies for self-care among African America psychologists*. (Unpublished doctoral thesis). The California School of Professional Psychology, CA.	No direct measure of stress/burnout/coping
18	Darden, A. J., & Rutter, P. A. (2011). Psychologists' experiences of grief after client suicide: A qualitative study. *OMEGA*. 63(4), 317-342.	Qualitative research
19	Darongkamas, J., Burton, M. V., & Cushway, D. (1994). The use of personal therapy by clinical psychologists working in the NHS in the United Kingdom. *Clinical Psychology and Psychotherapy*. 1(3), 165-173.	Insufficient data available
20	Deutsch, C. J. (1984). Self-reported sources of stress among psychotherapists. *Professional Psychology: Research and Practice*. 15(6), 833-845.	Participants not solely Clinical Psychologists
21	Dozier, S. L. (2001). *On becoming a therapist: An examination of psychology doctoral student's satisfaction with training, affective state, functioning and self-perceived clinical competence*. (Unpublished doctoral thesis). The Chicago School of Professional	Focus of research was trainee Clinical Psychologists

	Psychology. IL.	
22	Dunan, J. (1997). Ecstasy for clinical psychologists. *Clinical Psychology Forum*. 107, 11-14	No direct measure of stress/burnout/coping
23	Emery, S., Wade, T. D., & McLean, S. (2009). Associations among therapist beliefs, personal resources and burnout in clinical psychologists. *Behaviour Change*. 26(2), 89-96.	Insufficient data available
24	Engle, N, W. (2014) *Stressors and resources of Oregon Psychologists: How are helpers being helped?* (Unpublished doctoral thesis). George Fox University, OR.	Participants not solely Clinical Psychologists
25	Euler, J. R. (2004). *The impact of peer socialization on the experience of becoming a clinical psychologist: A qualitative analysis*. (Unpublished doctoral thesis). Alliant International University, LA.	Qualitative research
26	Farber, B. A. (1985). Clinical Psychologists' perceptions of psychotherapeutic work. *Clinical Psychologist,* 38(1), 10-13.	Full text unavailable
27	Ferrari, J., Dobis, K., Kardaras, E., Michna, D., Wagner, J., Sierawski, S., & Boyer, P. (1999) Community volunteerism among college students and professional psychologists: Does taking them to the streets make a difference? *Journal of Prevention and Intervention in the Community*. 18 (1-2), 35-51.	No direct measure of stress/burnout/coping Full text unavailable
28	Fortener, R. G. (1999). *Relationship between work setting, client prognosis, suicide ideation and burnout in psychologists and counsellors*. (Unpublished doctoral thesis). The University of Toledo, OH.	Participants not solely Clinical Psychologists
29	Gibson, K., Sandenbergh, R., & Swartz, L. (2001). Becoming a community clinical psychologist: Integration of community and clinical practices in psychologists' training. *South Africa Journal of Psychology*. 31 (1), 29-35.	No direct measure of stress/burnout/coping
30	Golliher, E. M. (1994). *The Relationship of job satisfaction to level of experience of clinical psychologists and psychiatrists*. (Unpublished doctoral thesis). Norfolk State University, VA.	Participants not solely Clinical Psychologists
31	Guerra Vio, C., Piatz, A. M., Bermudez, A. N., & Vidal, N. R. (2011). Psychometric examination of the self-care behaviors scale for clinical psychologists. *Latinoamericana de Psicologia,* 43 (2), 319-328.	Unavailable in English Language
32	Guerra, C., Rodriguez, K., Morales, G., &	Unavailable in English

	Betta, R. (2008). Preliminary validation of the self-care behaviors scale for clinical psychologists. *Psykhe,* 17(2), 67-78.	Language
33	Gwozdz, L. A. (2010). *A proposal to incorporate mindfulness practices into clinical psychology training*. (Unpublished doctoral thesis). Antioch University, New England.	No direct measure of stress/burnout/coping
34	Harris, C. K. (2010). *The use of values-enhanced mindfulness-based stress reduction to increase self-care behaviors and well-being in clinical psychology trainees*. (Unpublished doctoral thesis). Hofstra University, NY.	Focus of research was trainee Clinical Psychologists
35	Hellman, I. D., Morrison, T. L., & Abramowitz, S. I. (1987). Therapist experience and the stresses of psychotherapeutic work. *Psychotherapy*. 24 (2), 171-177.	Participants not solely Clinical Psychologists
36	Hill, K., Wittkowski, A., Hodgkinson, E., Bell, R., & Hare, D. J. (2016). Using the repertory grid technique to examine trainee clinical psychologists' construal or their personal and professional development. *Clinical Psychology and Psychotherapy*. 23, 425-437.	Focus of research was trainee Clinical Psychologists
37	Hopkins, A., & Proeve, M. (2013). Teaching mindfulness-based cognitive therapy to trainee psychologists: Qualitative and quantitative effects. *Counselling Psychology Quarterly*. 26 (2), 115-130.	Focus of research was trainee Clinical Psychologists
38	Ivicic, R., & Motta, R. (2016). Variables associated with secondary traumatic stress among mental health professionals. Traumatology.	Participants not solely Clinical Psychologists
39	Jordaan, I., Spangenberg, J. J., Watson, M. B., & Fouche, P. (2007). Emotional stress and coping strategies in South African clinical and counselling psychologists. *South African Journal of Psychology*. 37(4), 835-855.	Participants not solely Clinical Psychologists
40	Kahill, S. (1986). *Burnout among professional psychologists and its relationship to professional expectations and social support*. (Unpublished doctoral thesis). York University, Canada.	Participants not solely Clinical Psychologists
41	Kleespies, P. M., Smith, M. R., & Becker, B, R. (1990). Psychology interns as patient suicide survivors: Incidence, impact and recovery. *Professional Psychology: Research and Practice*. 21(4), 257-263.	Focus of research was trainee Clinical Psychologists
42	Krough, K. E. J. (1996). *The relations between gender roles, boundary permeability, and*	Insufficient data available

	burnout in psychologists. (Unpublished doctoral thesis). California School of Professional Psychology, CA.	
43	Kuyken, W., Peters, E., Power, M., Lavender, T., & Rabe-Hesketh, S. (2000) A longitudinal study of the psychological adaptation of trainee clinical psychologists. *Clinical Psychology and Psychotherapy*. 7, 394-400.	Focus of research was trainee Clinical Psychologists
44	Lovell, J. (1996). *Effects of managed mental health care on attitudes of psychotherapists about their work, their clients and the future of psychotherapy*. (Unpublished doctoral thesis). California Graduate Institute, CA.	No direct measure of stress/burnout/coping
45	Macdonald, B. (2009). A psychologist in crisis. *Clinical Psychology Forum*. 196, 18-21.	No direct measure of stress/burnout/coping
46	Maldonado Feliciano, L. E. (2005) *Coping, social support, biculturalism, and religious coping as moderators of the relationship between occupational stress and depressive affect among Hispanic psychologists*. (Unpublished doctoral thesis). University of Maryland, MD.	Participants not solely Clinical Psychologists
47	Martus, M. (2015). *The experience imparted by the elder clinical psychologist through an exit interview*. (Unpublished doctoral thesis). Michigan School of Professional Psychology, MI.	Qualitative research
48	Matlon, R. L. (2014). *An examination of the relationships between maladaptive versus adaptive perfectionism, stress, self-efficacy, and burnout in licensed clinical psychologists*. (Unpublished doctoral thesis). Wright Institute Graduate School of Psychology, CA.	Insufficient data available
49	McMahon, A. (2015). *The effects of didactic and experiential CBT training on mindfulness and burnout for clinical psychology graduate students*. (Unpublished doctoral thesis). The Chicago School of Professional Psychology. IL.	Focus of research was trainee Clinical Psychologists
50	Mehrotra S., Rao, K., & Subbakrishna, D. K. (2000). Factor structure of the mental health professionals stress scale (MHPSS) among clinical psychologists in India. *International Jounral of Social Psychiatry*. 46 (2), 142-150.	No direct measure of stress/burnout/coping
51	Mintz, E. E. (1957). Personal problems and diagnostic errors of clinical psychologists. *Journal of Projective Techniques*. 21(2), 123-128.	No direct measure of stress/burnout/coping

52	Mollen, P. (1989). Anxiety, supervision and a space for thinking: Some narcissistic perils for clinical psychologists in learning psychotherapy. *British Journal of Medical Psychology*. 62, 113-122.	No direct measure of stress/burnout/coping
53	Moore, P. (2008). Introducing mindfulness to clinical psychologists in training: An experiential course of brief exercises. *Journal of Clinical Psychology in Medical Settings*. 15, 331-337.	Focus of research was trainee Clinical Psychologists
54	Mulrine, J. L. (2016). *Psychologists' experience conducting child custody evaluations: stress and self-care*. (Unpublished doctoral thesis). Chestnut Hill College, PA.	No direct measure of stress/burnout/coping
55	Murtagh, M. P. (1991) *Effects of clinical practice on the psychologist: Perceived stress, short-term effects of treating depressed clients, and ways of coping*. (Unpublished doctoral thesis). University of Montana, MT.	Participants not solely Clinical Psychologists
56	Murtagh, M. P., & Wollersheim, J. P. (1997). Effects of clinical practice on psychologists: Treating depressed clients, perceived stress, and ways of coping. *Professional Psychology: Research and Practice*. 28(4), 361-364.	Insufficient data available
57	Nordgreen, T., & Havik, O. E. (2011). Use of self-help materials for anxiety and depression in mental health services: A national survey of psychologists in Norway. *Professional Psychology: Research and Practice*. 42(2), 185-191.	No direct measure of stress/burnout/coping
58	Olivares, R. B., Messerer, G. M., Ureta, K. R., & Guerra, C. (2007). The frequency of self-care emission behaviors and its relation with secondary traumatic stress and depression levels in clinical psychologists. *Pensamiento Psicologico*. 3(9), 9-19.	Unavailable in English Language Full text unavailable
59	Patterson-Hyatt, K. G. (2016). *Distress among psychologists: Prevalence, barriers and remedies for accessing mental health care*. (Unpublished doctoral thesis). Antioch University Seattle, WA.	Not empirical research (e.g. book chapter)
60	Pillay, A. L., & Harvey, B. M. (2006). The experiences of the first South African community service clinical psychologists. *South African Journal of Psychology*. 36(2), 259-280.	No direct measure of stress/burnout/coping
61	Rimes, K. A., & Wingrove, J. (2011). Pilot study of mindfulness-based cognitive therapy	Focus of research was trainee Clinical

	for trainee clinical psychologists. *Behavioural and Cognitive Psychotherapy*. 39, 235-241.	Psychologists
62	Rodriguez Vega, B., Melero-Liorente, J., Bayon Perez, C., Cebolla, S., Mira, J., Valverde, C., & Fernandez-Liria, A. (2013). Impact of mindfulness training on attentional control and anger regulation processes for psychotherapists in training. *Psychotherapy Research*. 24 (2), 202-213.	No direct measure of stress/burnout/coping Participants not solely Clinical Psychologists
63	Rohleder, P., Miller, M., & Smith, R. (2006). Doing time: Clinical psychologists' experience of community service in a prison placement. *South African Journal of Psychology*. 36(4), 795-812.	No direct measure of stress/burnout/coping
64	Rupert, P. A., & Morgan, D. J. (2005). Work setting and burnout among professional psychologists. *Professional Psychology: Research and Practice*. 36(5), 544-550.	Participants not solely Clinical Psychologists
65	Sakhrani, K. (2015). *The relationship between stress, burnout and coping strategies among prison psychologists: A phenomenological study*. (Unpublished doctoral thesis). The Chicago School of Professional Psychology. IL.	Qualitative research
66	Sanders, K. (2007). *Stressors and enhancers in the marital life of the clinical psychologist*. (Unpublished doctoral thesis). The Chicago School of Professional Psychology. IL.	No direct measure of stress/burnout/coping
67	Sanzovo, C. E., & Coelho, M. E. C. (2007). Clinical Psychologists' stress sources and coping strategies. *Estudos de Psicologia*. 24(2), 227-238.	Unavailable in English Language
68	Schimpf, T. (2009). *Personality traits and burnout in clinical psychologists*. (Unpublished doctoral thesis). Walden University, MN.	Insufficient data available
69	Schneider, K., & Rees, C. (2012). Evaluation of a combined cognitive behavioural therapy and interpersonal process group in the psychotherapy training of clinical psychologists. *Australian Psychologist*. 47, 137-146.	Focus of research was trainee Clinical Psychologists
70	Shapiro, A. B. (2012). *Burnout, vicarious traumatization and mindfulness in clinicians*. (Unpublished doctoral thesis). Pacific Graduate School of Psychology, CA.	Participants not solely Clinical Psychologists
71	Shelton, R. R. (2001). *Ego defences as buffers against stress and burnout in clinical psychologists*. (Unpublished doctoral thesis).	Participants not solely Clinical Psychologists

	Pepperdine University, CA.	
72	Stevanovic, P., & Rupert, P. A. (2004). Career-sustaining behaviors, satisfactions, and stresses of professional psychologists. *Psychotherapy: Theory, Research, Practice, Training*. 41(3), 301-309.	Participants not solely Clinical Psychologists
73	Torrado Oubina, V. M., Martinez Calvo, M. C., & Fernandez-Rios, L. (1997). Occupational stress and state of health among clinical psychologists and psychiatrists. *Psychology in Spain*. 1(1), 63-71.	Participants not solely Clinical Psychologists
74	Van Morkhoven, N. D. (1997). *The prevalence of burnout among psychologists and psychological associates in the state of Texas*. (Unpublished doctoral thesis). University of Texas, TX.	Participants not solely Clinical Psychologists
75	Vredenburgh, L. D. (1992) *Relationship between counselling psychologist burnout, type of practice setting, and selected demographic variables*. (Unpublished doctoral thesis). Oklahoma State University, OK.	Participants not solely Clinical Psychologists
76	Walsh, S., & Cormack, M. (1994). 'Do as we say but not as we do': Organizational, professional and personal barriers to the receipt of support at work. *Clinical Psychology and Psychotherapy*. 1(2), 101-110.	No direct measure of stress/burnout/coping
77	White, J. (2011). Everything you always wanted to know about stress (but were afraid to ask) or Trying to reach the 'hard to reach'. *Clinical Psychology Forum*. 224, 13-16.	No direct measure of stress/burnout/coping
78	Wise, E. H., & Barnett, J. E. (2016). Self-care for psychologists. In J. E. Bartlett, J. Norcross, G. R. Vandenbos, D. K. Freedheim, L. F. Campbell (Eds.), *APA Handbook of clinical psychology: Education and profession,* (Vol. 5, pp. 209-222). US: APA.	Full text unavailable Not empirical research (e.g. book chapter)
79	Yaymadjian, I. (2016). *The Possible Relationship between Psychotherapists' personality types and risk levels for burnout*. (Unpublished doctoral thesis). The Chicago School of Professional Psychology, IL.	Participants not solely Clinical Psychologists
80	Yip, S. Y. C., Mak, W. W. S., Chio, F, H, N., & Law, R. W. (2016). The mediating role of self-compassion between mindfulness and compassion fatigue among therapists in Hong Kong. *Mindfulness*.	Participants not solely Clinical Psychologists
81	Yiukee, C., & Tange, C. S. (1995) Existential correlates of burnout among mental health	Participants not solely Clinical Psychologists

	professionals in Hong Kong. *Journal of Mental Health Counseling*. 17 (2).	
82	Zemirah, N, L. (2000). *Burnout and clinical psychology graduate students: A qualitative study of students' experiences and perceptions*. (Unpublished doctoral thesis). Indiana University of Pennsylvania, PA.	Focus of research was trainee Clinical Psychologists Qualitative Research

Appendix C – Systematic Review: Quality Criteria Guidance

Well-covered (2): This methodological issue was deemed fully addressed and clearly reported

Adequately addressed (1): This methodical issue was deemed partly addressed and reported adequately. Even if addressed, the paper is slightly lacking in this area.

Poorly addressed/not addressed/not reported (0): This methodological issue could not be deemed to be sufficiently addressed. OR even if addressed the paper is significantly lacking in this area.

Not applicable (0): it was not applicable for this paper to report on this methodological issue

Study Design

1. Study aims and hypotheses

2: Well-covered	Aims and any hypotheses were clearly defined with correlational analysis prespecified
1: Adequately addressed	Aims and any hypotheses only briefly covered or are unclear, with little clarity regarding analysis OR only aims or hypotheses were mentioned, not both.
0: Poorly/not addressed	Aims and any hypotheses and prespecified analysis were poorly/not addressed

2. Ethical considerations

2: Well-covered	The study had been subject to independent ethical scrutiny
1: Adequately addressed	N/A
0: Poorly/not addressed	The ethical considerations/approval process of completing the research was not addressed/reported

Sample

3. Representativeness of sample

2: Well-covered	Representativeness of the sample was clearly reported and defined. Subjects were representative of the larger population, of which was described. Good balance of gender/age etc.
1: Adequately addressed	Representativeness of the sample was adequately reported/Subjects were partially representative of the population. Larger population was not described. Adequate balance of gender/age etc.
0: Poorly/not addressed	Representativeness of the sample was not addressed/subjects were not representative of the population. Insufficient balance of gender/age etc.

4. Response rate

2: Well-covered	The response rate was reported and reflected upon e.g. compared to other similar studies
1: Adequately addressed	The response rate was reported but not reflected upon
0: Poorly/not addressed	Response rate was not reported

5. Missing data

2: Well-covered	Any missing data was explained and if there was any then what they did was explained e.g. removal/compensatory measures were performed
1: Adequately addressed	Missing data was reported but there was no explanation about what was done
0: Poorly/not addressed	Missing data was not addressed

Measures used

6. Quality of measures

2: Well-covered	Choice of measure was justified with reference to reliability and validity referring to prior research. Prior analysis of reliability reported with reference to publications showing acceptable reliability. Validity (e.g. construct validity) was clearly discussed, prior analysis of validity reported with reference to this population, or similar. If using a measure developed by the author(s), effort had been made to provide information regarding the reliability and validity of the measure
1: Adequately addressed	Choice of measure adequately justified, but with no reference to prior research. Psychometric properties of measures were addressed but only adequately reported or any prior reliability/validity research reported was in relation to a different population.
0: Poorly/not addressed	Little/no information regarding the psychometric qualities OR the measure has poor validity/reliability

Analysis

7. Participant demographics reported

2: Well-covered	Demographics were clearly described e.g. participants age, gender, number of years working in role, marital status
1: Adequately addressed	Some (e.g. 3/4 aspects described above) demographic

	information was presented
0: Poorly/not addressed	Minimal (e.g. < 3/4 aspects described above) demographic information was presented

8. Statistical analyses

2: Well-covered	Statistical analyses were described and were appropriate for the design of the study and to address the aims/test their hypotheses. Correlations were included to look for variables impacting upon stress/burnout/coping. Enough information was included to allow replication
1: Adequately addressed	Statistical analyses was mostly appropriate to the design and measures with sufficient details to allow replication. Correlations were included to look for some of the variables impacting upon stress/burnout/coping.
0: Poorly/not addressed	Statistical analyses not fully addressed/explained or some analysis did not sufficiently match the study design. Correlations were not included to look for variables impacting upon stress/burnout/coping.

Results

9. Conclusions

2: Well-covered	Conclusions were in line with the results and were cautious considering the sample size, methodology etc. Generalisability was discussed in line with the outcomes
1: Adequately addressed	Conclusions/generalisability were somewhat over-stated or under-stated when considering the sample size etc.
0: Poorly/not addressed	Conclusions/generalisability were not in line with the research method and findings

10. Limitations

2: Well-covered	Limitations of the study were clearly expressed and identified. Possible future directions are suggested.
1: Adequately addressed	Limitations of the study were adequately addressed.
0: Poorly/not addressed	Limitations were poorly addressed or not mentioned.

Appendix D – Empirical Research: Author guidelines for Journal of Applied Research in Intellectual Disabilities

The journal to which you are submitting your manuscript employs a plagiarism detection system. By submitting your manuscript to this journal you accept that your manuscript may be screened for plagiarism against previously published works.

1. GENERAL

The *Journal of Applied Research in Intellectual Disabilities* is an international, peer-reviewed journal which draws together findings derived from original applied research in intellectual disabilities. The journal is an important forum for the dissemination of ideas to promote valued lifestyles for people with intellectual disabilities. It reports on research from the UK and overseas by authors from all relevant professional disciplines. It is aimed at an international, multi-disciplinary readership.

The topics it covers include community living, quality of life, challenging behaviour, communication, sexuality, medication, ageing, supported employment, family issues, mental health, physical health, autism, economic issues, social networks, staff stress, staff training, epidemiology and service provision. Theoretical papers are also considered provided the implications for therapeutic action or enhancing quality of life are clear. Both quantitative and qualitative methodologies are welcomed. All original and review articles continue to undergo a rigorous, peer-refereeing process.

Please read the instructions below carefully for details on submission of manuscripts, the journal's requirements and standards as well as information concerning the procedure after a manuscript has been accepted for publication. Authors are encouraged to visit http://authorservices.wiley.com.ezproxy.is.ed.ac.uk/bauthor/ for further information on the preparation and submission of articles.

All manuscripts must be submitted solely to this journal and not published, in press, or submitted elsewhere.

2. ETHICAL GUIDELINES

Acceptance of papers is based on the understanding that authors have treated research participants with respect and dignity throughout. Please see Section 2.2 below.

2.1 Authorship and Acknowledgements

Authorship: Authors submitting a paper do so on the understanding that the manuscript has been read and approved by all authors and that all authors agree to the submission of the manuscript to the journal. ALL named authors must have made an active contribution to the conception and design and/or analysis and interpretation of the data and/or the drafting of the paper and ALL authors must have critically reviewed its content and have approved the final version submitted for publication.

Participation solely in the acquisition of funding or the collection of data does not justify authorship.
It is a requirement that all authors have been accredited as appropriate under submission of the manuscript. Contributors who do not qualify as authors should be mentioned under Acknowledgements.

Acknowledgements: Under Acknowledgements please specify contributors to the article other than the authors accredited. Please also include specifications of the source of funding for the study and any potential conflict of interest if appropriate. Suppliers of materials should be named and their location (town, state/county, country) included.

2.2 Ethical Approvals

Research involving human participants will only be pubished if such research has been conducted in full accordance with ethical principles, including the World Medical Association Declaration of Helsinki (version, 2002 www.wma.net) and the additional requirements, if any, of the country where the research has been carried out. Manuscripts must be accompanied by a statement that the research was undertaken with the understanding and written consent of each participant (or the participant's representative, if they lack capacity), and according to the above mentioned principles. A statement regarding the fact that the study has been independently reviewed and approved by an ethical board should also be included. All studies using human participants should include an explicit statement in the Material and Methods section identifying the review and ethics committee approval for each study, if applicable. Editors reserve the right to reject papers if there is doubt as to whether appropriate procedures have been used.

Ethics of investigation: Papers not in agreement with the guidelines of the Helsinki Declaration as revised in 1975 will not be accepted for publication.

2.3 Clinical Trials

Clinical trials should be reported using the CONSORT guidelines available at www.consort-statement.org. A CONSORT checklist should also be included in the submission material (www.consort-statement.org).
The *Journal of Applied Research in Intellectual Disabilities* encourages authors submitting manuscripts reporting from a clinical trial to register the trials in any of the following free, public trials registries: www.clinicaltrials.org, www.isrctn.org. The clinical trial registration number and name of the trial register will then be published with the paper.

2.4 Conflict of Interest and Source of Funding

Conflict of Interest: Authors are required to disclose any possible conflict of interest. These include financial (for example patent ownership, stock ownership, consultancies, speaker's fee). Author's conflict of interest (or information specifying the absence of conflict of interest) will be published under a separate heading.

The *Journal of Applied Research in Intellectual Disabilities* requires that sources of institutional, private and corporate financial support for the work within the manuscript must be fully acknowledged, and any potential conflict of interest noted. As of 1st March 2007, this information is a requirement for all manuscripts submitted to the journal and will be published in a highlighted box on the title page of the article. Please include this information under the separate headings of 'Source of Funding' and 'Conflict of Interest' at the end of the manuscript.
If the author does not include a conflict of interest statement in the manuscript, then the following statement will be included by default: 'No conflict of interest has been declared'.

Source of Funding: Authors are required to specify the source of funding for their research when submitting a paper. Suppliers of materials should be named and their location (town, state/county, country) included. The information will be disclosed in the published article.

2.5 Permissions

If all or parts of previously published illustrations are used, permission must be obtained from the copyright holder concerned. It is the author's responsibility to obtain these in writing and provide copies to the Publishers.

2.6 Copyright Assignment

If your paper is accepted, the author identified as the formal corresponding author for the paper will receive an email prompting them to login into Author Services; where via the Wiley Author Licensing Service (WALS) they will be able to complete the license agreement on behalf of all authors on the paper.

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If the OnlineOpen option is not selected the corresponding author will be presented with the copyright transfer agreement (CTA) to sign. The terms and conditions of the CTA can be previewed in the samples associated with the Copyright FAQs below:

CTA Terms and
Conditions http://authorservices.wiley.com.ezproxy.is.ed.ac.uk/bauthor/faqs_copyright.asp

3. ONLINEOPEN

For authors choosing OnlineOpen

If the OnlineOpen option is selected the corresponding author will have a choice of the following Creative Commons License Open Access Agreements (OAA):

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To preview the terms and conditions of these open access agreements please visit the Copyright FAQs hosted on Wiley Author Services http://authorservices.wiley.com.ezproxy.is.ed.ac.uk/bauthor/faqs_copyright.asp and visit http://www.wileyopenaccess.com.ezproxy.is.ed.ac.uk/details/content/12f25db4c87/Copyright--License.html.
If you select the OnlineOpen option and your research is funded by The Wellcome Trust and members of the Research Councils UK (RCUK) you will be given the opportunity to publish your article under a CC-BY license supporting you in complying with Wellcome Trust and Research Councils UK requirements. For more information on this policy and the Journal's compliant self-archiving policy please visit: http://www.wiley.com.ezproxy.is.ed.ac.uk/go/funderstatement.

4. SUBMISSION OF MANUSCRIPTS

Submissions are now made online using ScholarOne Manuscripts (formerly Manuscript Central). To submit to the journal go to http://mc.manuscriptcentral.com/jarid. If this is the first time you have used the system you will be asked to register by clicking on 'create an account'. Full instructions on making your submission are provided. You should receive an acknowledgement within a few minutes. Thereafter, the system will keep you informed of the process of your submission through refereeing, any revisions that are required and a final decision.

4.1 Manuscript Files Accepted

Manuscripts should be uploaded as Word (.doc) or Rich Text Format (.rft) files (not write-protected) plus separate figure files. GIF, JPEG, PICT or Bitmap files are acceptable for submission, but only high-resolution TIF or EPS files are suitable for printing.

To allow double-blinded review, please upload your manuscript and title page as **separate** files.

Please upload:
1. Your manuscript without title page under the file designation 'main document'.
2. Figure files under the file designation 'figures'.
3. Title page which should include title, authors (including corresponding author contact details), acknowledgements and conflict of interest statement where applicable, should be uploaded under the file designation 'title page'.

All documents uploaded under the file designation 'title page' will not be viewable in the HTML and PDF format you are asked to review at the end of the submission process. The files viewable in the HTML and PDF format are the files available to the reviewer in the review process.

Please note that any manuscripts uploaded as Word 2007 (.docx) will be automatically rejected. Please save any .docx files as .doc before uploading.

4.2 Blinded Review

All articles submitted to the journal are assessed by at least two anonymous reviewers with expertise in that field. The Editors reserve the right to edit any contribution to ensure that it conforms with the requirements of the journal.

5. MANUSCRIPT TYPES ACCEPTED

Original Articles, Review Articles, Brief Reports, Book Reviews and ***Letters to the Editor*** are accepted. ***Theoretical Papers*** are also considered provided the implications for therapeutic action or enhancing quality of life are clear. Both quantitative and qualitative methodologies are welcomed. Articles are accepted for publication only at the discretion of the Editor. Articles should not exceed 7000 words. Brief Reports should not normally exceed 2000 words. Submissions for the Letters to the Editor section should be no more than 750 words in length.

6. MANUSCRIPT FORMAT AND STRUCTURE

6.1 Format

Language: The language of publication is English. Authors for whom English is a second language must have their manuscript professionally edited by an English speaking person before submission to make sure the English is of high quality. It is preferred that manuscripts are professionally edited. A list of independent suppliers of editing services can be found at http://authorservices.wiley.com.ezproxy.is.ed.ac.uk/bauthor/english_language.asp. All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

6.2 Structure

All manuscripts submitted to the *Journal of Applied Research in Intellectual Disabilities* should include:

Cover Page: A cover page should contain only the title, thereby facilitating anonymous reviewing. The authors' details should be supplied on a separate page and the author for correspondence should be identified clearly, along with full contact details, including e-mail address.

Running Title: A short title of not more than fifty characters, including spaces, should be provided.

Keywords: Up to six key words to aid indexing should also be provided.

Main Text: All papers should have a structured abstract (maximum 150 words) as follows: Background, Method, Results, and Conclusions. The abstract should provide an outline of the research questions, the design, essential findings and main conclusions of the study. Authors should make use of headings within the main paper as follows: Introduction, Method, Results and Discussion. Subheadings can be used as appropriate. All authors must clearly state their research questions, aims or hypotheses clearly at the end of the Introduction. Figures and Tables should be

submitted as a separate file.
Style: Manuscripts should be formatted with a wide margin and double spaced. Include all parts of the text of the paper in a single file, but do not embed figures. Please note the following points which will help us to process your manuscript successfully:
-Include all figure legends, and tables with their legends if available.
-Do not use the carriage return (enter) at the end of lines within a paragraph.
-Turn the hyphenation option off.
-In the cover email, specify any special characters used to represent non-keyboard characters.
-Take care not to use l (ell) for 1 (one), O (capital o) for 0 (zero) or ß (German esszett) for (beta).
-Use a tab, not spaces, to separate data points in tables.
-If you use a table editor function, ensure that each data point is contained within a unique cell, i.e. do not use carriage returns within cells.
Spelling should conform to *The Concise Oxford Dictionary of Current English* and units of measurements, symbols and abbreviations with those in *Units, Symbols and Abbreviations* (1977) published and supplied by the Royal Society of Medicine, 1 Wimpole Street, London W1M 8AE. This specifies the use of S.I. units.

6.3 References

APA - American Psychological Association

References should be prepared according to the Publication Manual of the American Psychological Association (6th edition). This means in text citations should follow the author-date method whereby the author's last name and the year of publication for the source should appear in the text, for example, (Jones, 1998). The complete reference list should appear alphabetically by name at the end of the paper.

A sample of the most common entries in reference lists appears below. Please note that a DOI should be provided for all references where available. For more information about APA referencing style, please refer to the APA FAQ. Please note that for journal articles, issue numbers are not included unless each issue in the volume begins with page one.

Journal article

Beers, S. R. , & De Bellis, M. D. (2002). Neuropsychological function in children with maltreatment-related posttraumatic stress disorder. The American Journal of Psychiatry, 159, 483–486. doi:10.1176/appi.ajp.159.3.483

Book Edition

Bradley-Johnson, S. (1994). Psychoeducational assessment of students who are visually impaired or blind: Infancy through high school (2nd ed.). Austin, TX: Pro-ed.

6.4 Tables, Figures and Figure Legends

Tables should include only essential data. Each table must be typewritten on a separate sheet and should be numbered consecutively with Arabic numerals, e.g. Table 1, and given a short caption.

Figures should be referred to in the text as Figures using Arabic numbers, e.g. Fig.1, Fig.2 etc, in order of appearance. Figures should be clearly labelled with the name of the first author, and the appropriate number. Each figure should have a separate legend; these should be grouped on a separate page at the end of the manuscript. All symbols and abbreviations should be clearly explained. In the full-text online edition of the journal, figure legends may be truncated in abbreviated links to the full screen version. Therefore, the first 100 characters of any legend should inform the reader of key aspects of the figure.

Preparation of Electronic Figures for Publication
Although low quality images are adequate for review purposes, print publication requires high quality images to prevent the final product being blurred or fuzzy. Submit EPS (line art) or TIFF (halftone/photographs) files only. MS PowerPoint and Word Graphics are unsuitable for printed pictures. Do not use pixel-oriented programmes. Scans (TIFF only) should have a resolution of at least 300 dpi (halftone) or 600 to 1200 dpi (line drawings) in relation to the reproduction size. Please submit the data for figures in black and white or submit a Colour Work Agreement Form. EPS files should be saved with fonts embedded (and with a TIFF preview if possible).
Further information can be obtained at Wiley-Blackwell's guidelines for figures: http://authorservices.wiley.com.ezproxy.is.ed.ac.uk/bauthor/illustration.asp.
Check your electronic artwork before submitting it: http://authorservices.wiley.com.ezproxy.is.ed.ac.uk/bauthor/eachecklist.asp.
Permissions: If all or parts of previously published illustrations are used, permission must be obtained from the copyright holder concerned. It is the author's responsibility to obtain these in writing and provide copies to the Publisher.
Colour Charges: It is the policy of the *Journal of Applied Research in Intellectual Disabilities* for authors to pay the full cost for the reproduction of their colour artwork. Colour Work Agreement Form can be downloaded here.

7. AFTER ACCEPTANCE
Upon acceptance of a paper for publication, the manuscript will be forwarded to the Production Editor who is responsible for the production of the journal.

7.1 Proof Corrections
The corresponding author will receive an e-mail alert containing a link to a website. A working e-mail address must therefore be provided for the corresponding author. The proof can be downloaded as a PDF file from this site.

Acrobat Reader will be required in order to read this file. This software can be downloaded (free of charge) from the following website:
www.adobe.com/products/acrobat/readstep2.html
This will enable the file to be opened, read on screen, and printed out in order for any corrections to be added. Further instructions will be sent with the proof. Proofs will be posted if no e-mail address is available; in your absence, please arrange for a colleague to access your e-mail to retrieve the proofs.

Proofs must be returned to the Production Editor within 3 days of receipt.
As changes to proofs are costly, we ask that you only correct typesetting errors. Excessive changes made by the author in the proofs, excluding typesetting errors, will be charged separately. Other than in exceptional circumstances, all illustrations are retained by the Publisher. Please note that the author is responsible for all statements made in their work, including changes made by the copy editor.

7.2 Early View (Publication Prior to Print)
The *Journal of Applied Research in Intellectual Disabilities* is covered by Wiley-Blackwell's Early View service. Early View articles are complete full-text articles published online in advance of their publication in a printed issue. Early View articles are complete and final. They have been fully reviewed, revised and edited for publication, and the authors' final corrections have been incorporated. Because they are in final form, no changes can be made after online publication. The nature of Early View articles means that they do not yet have a volume, issue or page number, so Early View articles cannot be cited in the traditional way. They are therefore given a DOI (digital object identifier) which allows the article to be cited and tracked before it is allocated to an issue. After print publication, the DOI remains valid and can continue to be used to cite and access the article.

7.3 Author Services
Online production tracking is available for your article through Wiley-Blackwell's Author Services. Author Services enables authors to track their article - once it has been accepted - through the production process to publication online and in print. Authors can check the status of their articles online and choose to receive automated e-mails at key stages of production. The author will receive an e-mail with a unique link that enables them to register and have their article automatically added to the system. Please ensure that a complete e-mail address is provided when submitting the manuscript. Visit http://authorservices.wiley.com.ezproxy.is.ed.ac.uk/bauthor/ for more details on online production tracking and for a wealth of resources include FAQs and tips on article preparation, submission and more.
For more substantial information on the services provided for authors, please see Wiley-Blackwell's Author Services.

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Appendix E (i) – Empirical Research: Confirmation of Local Research and Development Approval. NHS Tayside.

NHS
Tayside

04 February 2016

Miss Emilly Scott
NHS Tayside Psychological Therapies Service
Wedderburn House
1 Edward Street
Dundee
DD1 5NS

Dear Miss Scott,

R&D MANAGEMENT APPROVAL – TAYSIDE

Title: Working with People with Intellectual Disabilities and Behaviour that Challenges: Perspectives from Clinical Psychologists

Chief Investigator: Miss Emilly Scott

Principal Investigator/Local Collaborator: Dr Rowan Reffold

Tayside Ref: 2015PZ05 NRS Ref: NRS16/197314

REC Ref: N/A

Sponsor: University of Edinburgh

Funder: N/A

Many thanks for your application to carry out the above project here in NHS Tayside. I am pleased to confirm that the project documentation (as outlined below) has been reviewed, registered and Management Approval has been granted for the study to proceed locally in Tayside.

Approval is granted on the following conditions:-

- ALL Research must be carried out in compliance with the Research Governance Framework for Health & Community Care, Health & Safety Regulations, data protection principles, statutory legislation and in accordance with Good Clinical Practice (GCP).
- All amendments to be notified to TASC R&D Office via the correct amendment pathway. Either direct to the R&D Office or via the Lead Co-ordinating Centre depending on how the study is set up (http://www.hra.nhs.uk/nhshsc-rd-uk-process-management-amendments/).
- All local researchers must hold either a Substantive Contract, Honorary Research Contract, Honorary Clinical Contract or Letter of Access with NHS Tayside where required (http://www.nihr.ac.uk/policy-and-standards/research-passports.htm).
- TASC R&D Office to be informed of change in Principal Investigator, Chief Investigator or any additional research personnel locally.
- Notification to TASC R&D Office of any change in funding.

- As custodian of the information collated during this research project you are responsible for ensuring the security of all personal information collected in line with NHS Scotland IT Security Policies, until destruction of this data.

- All eligible and adopted studies will be added to the UKCRN Portfolio database http://public.ukcrn.org.uk/. Recruitment figures for eligible and adopted studies must be recorded onto the Portfolio every month. This is the responsibility of the lead UK site. If you are the lead, or only UK site, we can provide help or advice with this. For information, contact Sarah Kennedy (01382 383882 or sarah.kennedy17@nhs.net) or Margaret Marshall (01382 383091 or margaret.marshall7@nhs.net).

- Annual reports are required to be submitted to TASC R&D Office with the first report due 12 months from date of issue of this management approval letter and at yearly intervals until completion of the study.

- Notification of early termination within 15 days or End of Trial within 90 days followed by End of Trial Report within 1 year to TASC R&D Office.

- You may be required to assist with and provide information in regard to audit and monitoring of study.

Please note you are required to adhere to the conditions, if not, NHS management approval may be withdrawn for the study.

Approved Documents

Document	Version	Date
Protocol	**1**	**11/01/16**
IRAS R&D		
IRAS SSI		
Insurance		**01/08/15**
Insurance 2		**28/07/15**
Insurance 3		**28/07/15**
Insurance 4		**13/07/15**
PIS	**1**	**11/01/16**
Participant expression of interest	**1**	**11/01/16**
Consent	**1**	**11/01/16**
Interview schedule	**1**	**11/01/16**
Demographic information	**1**	**11/01/16**
CV – Rowan Reffold		**19/01/16**
CV – Kenneth Macmahon		
CV – Emilly Scott		

May I take this opportunity to wish you every success with your project.

Please do not hesitate to contact TASC R&D Office should you require further assistance.

Yours sincerely

Elizabeth Coote
Head of Non-Commercial Research Services

TAyside medical Science **C**entre (TASC)

Ninewells Hospital & Medical School
TASC Research & Development Office
Residency Block, Level 3
George Pirie Way
Dundee DD1 9SY
Email: liz.coote@nhs.net
Tel: 01382 383876 Fax: 01382 740122

c.c. Rowan Reffold
Margaret Marshall
TASC Feasibility Team

Appendix E (ii) – Empirical Research: Confirmation of Local Research and Development Approval. NHS Ayrshire and Arran.

Research & Development
58 Lister Street
University Hospital Crosshouse
Kilmarnock
KA2 0BB

Dr Helen Lynn
Consultant Clinical Psychologist
NHS Ayrshire & Arran
Arrol Park Resource Centre
Doonfoot Road
Ayr
KA7 4DW

Date 17 February 2016
Your Ref
Our Ref AG/KLB/AMK 2016AA006

Enquiries to Karen Bell
Extension 25850
Direct line 01563 825850
Fax 01563 825806
Email Karen.bell@aaaht.scot.nhs.uk

Dear Dr Lynn

Working with People with Intellectual Disabilities and Behaviour that Challenges: Perspectives from Clinical Psychologists

I confirm that NHS Ayrshire and Arran have reviewed the undernoted documents and grant R&D Management approval for the above study.

Documents received:

Document	Version	Date
IRAS R&D Form	5.2.1	20 January 2016
IRAS SSI	5.2.1	5 February 2016
Protocol	1.0	11 January 2016
Demographic Information	1.0	11 January 2016
Interview Schedule	1.0	11 January 2016
Consent Form	1.0	11 January 2016
Participant Expression of Interest	1.0	11 January 2016
Participant Information Form	1.0	11 January 2016

The terms of approval state that the investigator authorised to undertake this study within NHS Ayrshire & Arran is: -

- Miss Emilly Scott, NHS Tayside Psychological Therapies Service

With no additional investigators

The sponsor for this study is University of Edinburgh.

This approval letter is valid until **26 October 2017**.

Regular reports of the study require to be submitted. Your first report should be submitted to Dr K Bell, Research & Development Manager in 12 months time and subsequently at yearly intervals until the work is completed.

Please note that as a requirement of this type of study your name, designation, work address, work telephone number, work e-mail address, work related qualifications and whole time equivalent will be held on the Scottish National Research Database so that NHS R&D staff in Scotland can access this information for purposes related to project management and report monitoring.

In addition approval is granted subject to the following conditions: -

- All research activity must comply with the standards detailed in the Research Governance Framework for Health and Community Care www.cso.scot.nhs.uk/publications/ResGov/Framework/RGFEdTwo.pdf and appropriate statutory legislation. It is your responsibility to ensure that you are familiar with these, however please do not hesitate to seek further advice if you are unsure.

- Recruitment figures must be submitted to R&D on a monthly basis. If recruitment figures are not received timeously you will be contacted by a member of the R&D team to provide this data.

- You are required to comply with Good Clinical Practice (ICH-GCP guidelines may be found at www.ich.org/LOB/media/MEDIA482.pdf), Ethics Guidelines, Health & Safety Act 1999 and Data Protection Act 1998.

- If any amendments are to be made to the study protocol and or the Research Team the Researcher must seek Ethical and Management Approval for the changes before they can be implemented.

- The Researcher and NHS Ayrshire and Arran must permit and assist with any monitoring, auditing or inspection of the project by the relevant authorities.

- The NHS Ayrshire and Arran Complaints Department should be informed if any complaints arise regarding the project and the R&D Department must be copied into this correspondence.

- The outcome and lessons learnt from complaints must be communicated to funders, sponsors and other partners associated with the project.

- As custodian of the information collated during this research project you are responsible at all times for ensuring the security of all personal information collated in line with NHS Scotland policies on information assurance and security, until the secure destruction of these data. The retention time periods for such data should comply with the requirements of the Scottish Government Records Management: NHS Code Of Practice. Under no circumstances should personal data be stored on any unencrypted removable media e.g. laptop, USB or mobile device (for further information and guidance please contact the Information Governance Team based at University Hospital Crosshouse 01563 825831 or 826813).

If I can be of any further assistance please do not hesitate to contact me. On behalf of the department, I wish you every success with the project.

Yours sincerely

Dr Alison Graham
Medical Director

c.c. Jo-Anne Robertson, University of Edinburgh (sponsor contact)
Lesley Douglas, Finance, Ailsa Hospital
Information Governance, Ailsa Hospital
Emilly Scott, NHS Tayside Psychological Therapies Service
Dr Kenneth MacMahon, University of Edinburgh (academic supervisor)
Dr Rowan Reffold, NHS Tayside Psychological Therapies Service (academic supervisor)

Appendix E (iii)- Empirical Research: Confirmation of Local Research and Development Approval – NHS Forth Valley

Date: 01 June 2016

Your Ref:

Our Ref:
Direct Line: 01324 677564
Email: Allyson.bailey @nhs.net
R&D ref: FV 933

Emilly Scott
Trainee Clinical Psychologist
Centre for Child Health
19 Dudhope Terrace
Dundee
DD3 6HH

Dear Ms Scott

Study title: Psychologists' perspectives of working with ID and challenging behaviour
NRES number: N/A

I am pleased to confirm that I formally gave Management Approval to the study above on 1 June 2016.

This approval is granted subject to your compliance with the following:

1. Any amendments to the protocol or research team must have Ethics Committee and R&D approval (as well as approval from any other relevant regulatory organisation) before they can be implemented. Please ensure that the R&D Office and (where appropriate) NRS are informed of any amendments as soon as you become aware of them.

2. You and any local Principal Investigator are responsible for ensuring that all members of the research team have the appropriate experience and training, including GCP training if required.

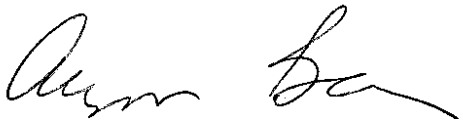
3. All those involved in the project will be required to work within accepted guidelines of health and safety and data protection principles, any other relevant statutory legislation, the Research Governance Framework for Health and Community Care and IHC-GCP guidelines. A copy of the Framework can be accessed via the Chief Scientist Office website at:
http://www.cso.scot.nhs.uk/Publications/ResGov/Framework/RGFEdTwo.pdf
and ICH-GCP guidelines may be found at
http://www.ich.org/LOB/media/MEDIA482.pdf

4. As custodian of the information collected during this project you are responsible for ensuring the security of all personal information collected in line with NHS Scotland IT security policies, until the destruction of this data.

5. You or the local Principal Investigator will be required to provide the following reports and information during the course of your study:
A progress report **annually**
Recruitment numbers on **a monthly** basis (if your study should be added to the NIHR research Portfolio you will receive a separate letter from the R&D Office detailing the steps to be taken)
Report on SAEs and SUSARs if your study is a Clinical Trial of an Investigational Medicinal Product
Any information required for the purpose of internal or external audit and monitoring
Copies of any external monitoring reports
Notification of the end of recruitment and the end of the study
A copy of the final report, when available.
Copies of or full citations for any publications or abstracts

The appropriate forms will be provided to you by the Research and Development office when they are needed. Other information may be required from time to time.

Yours sincerely

pp 

MISS TRACEY GILLIES
Medical Director

CC: Jennifer borthwick

Appendix E (iv) - Empirical Research: Confirmation of Local Research and Development Approval – NHS Lothian

University Hospitals Division

NHS Lothian

Queen's Medical Research Institute
47 Little France Crescent, Edinburgh, EH16 4TJ

DY/GM/Approval

8th June 2016

Research & Development
Room E1.12
Tel: 0131 242 3330

Email:
R&DOffice@nhslothian.scot.nhs.uk

Director: Professor David E Newby

Dr Jan Ferris
West Lothian Learning Disability Service
Fairbairn House, Fairbairn Place
Livingston
EH54 6TN

Dear Dr Ferris,

Lothian R&D Project No: 2016/0180

Title of Research: Working with People with Intellectual Disabilities and Behaviour that Challenges: Perspectives from Clinical Psychologists

REC No: N/A

Participant Information Sheet:
Version 1 Dated 11th January 2016

Consent Form:
Version 1 Dated 11th January 2016

Protocol: Version 1 Dated 11th January 2016

I am pleased to inform you that this study has been approved for NHS Lothian and you may proceed with your research, subject to the conditions below. This letter provides Site Specific approval for NHS Lothian.

We note that this project includes a researcher who will require a Clinical Research Access letter from NHS Lothian. The individual concerned Emily Scott should contact our offices with a view to applying for the necessary documentation. Please note all final paperwork will have to be signed and returned to our R&D offices before the researcher can commence work on the project.
Please note that the NHS Lothian R&D Office must be informed if there are any changes to the study such as amendments to the protocol, recruitment, funding, personnel or resource input required of NHS Lothian.

Substantial amendments to the protocol will require approval from the ethics committee which approved your study and the MHRA where applicable.

Please inform this office when recruitment has closed and when the study has been completed.

I wish you every success with your study.

Yours sincerely

Dr Douglas Young
Principal R&D Manager

cc: Mr Tim Montgomery, Director of Operations, REH

STA034

Appendix E (v) - Empirical Research: Confirmation of Local Research and Development Approval – NHS Fife

Medical Director

Hayfield House
Hayfield Road
KIRKCALDY
KY2 5AH

NHS Fife

Miss Emily Scott
NHS Tayside Psychological Therapies Service
Wedderburn House
1 Edward Street
DUNDEE
DD1 5NS

22 March 2016
Our Ref *16-008 197314*

Enquiries to *Aileen Yell*
E-mail *aileenyell@nhs.net*
Telephone *01383 623623 Ext 20940*
Website *www.nhsfife.org*

Dear Miss Scott

Project Title: Psychologists' perspectives of working with ID and challenging behaviour

Thank you for your application to carry out the above project. Your project documentation (detailed below) has been reviewed for resource and financial implications for NHS Fife and I am happy to inform you that NHS permission for the above research has been granted on the basis described in the application form, protocol and supporting documentation. The documents reviewed were:

Document	Version	Date
Protocol	1	11 January 2016
Participant Expression of Interest	1	11 January 2016
Patient Information Sheet	1	11 January 2016
Consent Form	1	11 January 2016
Interview schedule	1	11 January 2016
UK Study-Wide Governance Report		1 February 2016
IRAS SSI Form	5.2.1	17 March 2016

The terms of the approval states that you are the investigator authorised to undertake this study within NHS Fife. **I understand that you may be coming to Fife to conduct interviews with staff. A Letter of Access is being processed by the R&D Office and you should ensure that this is in place prior to you attending in Fife.**

I note that review by an NHS Research Ethics Committee has not been necessary since the study involves NHS staff only.

The sponsors for this study are University of Edinburgh.

Details of our participation in studies will be included in annual returns we are expected to complete as part of our agreement with the Chief Scientist Office. Regular reports of the study require to be submitted. Your first report should be submitted to Dr A Wood, R&D Manager, R&D Department, Queen Margaret Hospital, Whitefield Rd, Dunfermline, KY12 OSU (Amanda.wood3@nhs.net) in 12 months time and subsequently at yearly intervals until the work is completed. A Lay Summary will also be required upon completion of the project.

In addition, approval is granted subject to the following conditions:-

All research activity must comply with the standards detailed in the Research Governance Framework for Health & Community Care

NHS Fife was awarded the Carbon Trust Standard in February 2010 and is the first Scottish NHS Board to achieve this accolade.

NHS
Fife

(http://www.cso.scot.nhs.uk/publications/resgov/resgov.htm), health & safety regulations, data protection principles, other appropriate statutory legislation and in accordance with Good Clinical Practice (GCP).

Any amendments which may subsequently be made to the study should also be notified to Aileen Yell, Research Governance Officer (aileenyell@nhs.net) , as well as the appropriate regulatory authorities. Notification should also be given of any new research team members post approval and/or any changes to the status of the project.

This organisation is required to monitor research to ensure compliance with the Research Governance Framework and other legal and regulatory requirements. This is achieved by random audit of research. You will be required to assist with and provide information in regard to monitoring and study outcomes (including providing recruitment figures to the R&D office as and when required).

As custodian of the information collated during this research project you are responsible for ensuring the security of all personal information collected in line with NHS Scotland IT Security Policies, until the destruction of this data.

Permission is only granted for the activities for which a favourable opinion has been given by the REC (and which have been authorised by the MHRA where appropriate).

The research sponsor or the Chief Investigator or local Principal Investigator at a research site may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety. The R&D office (aileenyell@nhs.net) should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action. The R&D office should be notified within the same time frame of notifying the REC and any other regulatory bodies.

I would like to wish you every success with your study and look forward to receiving a summary of the findings for dissemination once the project is complete.

Yours sincerely

DR FRANCES ELLIOT
Medical Director
NHS Fife

Cc : Aileen Yell, Research Governance Officer, NHS Fife, Queen Margaret Hospital, Dunfermline

Appendix E (vi) - Empirical Research: Confirmation of Local Research and Development Approval – NHS Lanarkshire

Miss Emilly Scott
Trainee Clinical Psychologist
NHS Tayside Psychological Therapies Service
Wedderburn House
1 Edward Street
Dundee, DD1 5NS

R&D Department
Corporate Services Building
Monklands Hospital
Monkscourt Avenue
AIRDRIE
ML6 0JS

Date 15.02.2016
Enquiries to Lorraine Quinn,
R&D Facilitator
Direct Line 01236 712445
Email lorraine.quinn@lanarkshire.scot.nhs.uk

Dear Miss Scott

Project title: Working with People with Intellectual Disabilities and Behaviour that Challenges: Perspectives from Clinical Psychologists

R&D ID: L16011

NRS ID Number: NRS16/197314

I am writing to you as Chief Investigator of the above study to advise that R&D Management approval has been granted for the conduct of your study within NHS Lanarkshire as detailed below:

NAME	TITLE	ROLE	NHSL SITE TO WHICH APPROVAL APPLIES
Ms Gillian Anderson	Consultant Clinical Psychologist	Local Collaborator	NHS Lanarkshire

For the study to be carried out you are subject to the following conditions:

Conditions

- You are required to comply with Good Clinical Practice, Ethics Guidelines, Health & Safety Act 1999 and the Data Protection Act 1998.
- The research is carried out in accordance with the Scottish Executive's Research Governance Framework for Health and Community Care (copy available via the Chief Scientist Office website: http://www.cso.scot.nhs.uk/ or the Research & Development Intranet site: http://firstport2/staff-support/research-and-development/default.aspx
- You must ensure that all confidential information is maintained in secure storage. You are further obligated under this agreement to report to the NHS Lanarkshire Data Protection Office and the

Research & Development Office infringements, either by accident or otherwise, which constitutes a breach of confidentiality.

- Clinical trial agreements (if applicable), or any other agreements in relation to the study, have been signed off by all relevant signatories.
- You must contact the Lead Nation Coordinating Centre if/when the project is subject to any minor or substantial amendments so that these can be appropriately assessed, and approved, where necessary.
- You notify the R&D Department if any additional researchers become involved in the project within NHS Lanarkshire
- You notify the R&D Department when you have completed your research, or if you decide to terminate it prematurely.
- You must send brief annual reports followed by a final report and summary to the R&D office in hard copy and electronic formats as well as any publications.
- If the research involves any investigators who are not employed by NHS Lanarkshire, but who will be dealing with NHS Lanarkshire patients, there may be a requirement for an SCRO check and occupational health assessment. If this is the case then please contact the R&D Department to make arrangements for this to be undertaken and an honorary contract issued.

I trust these conditions are acceptable to you.

Yours sincerely,

Raymond Hamill – Corporate R&D Manager

cc.

NAME	TITLE	CONTACT ADDRESS	ROLE
Ms Gillian Anderson	Consultant Clinical Psychologist	Kirklands Hospital	Local Collaborator
Jo-Anne Robertson	Research Governance Coordinator	University of Edinburgh	Sponsor Contact
Dr Kenneth MacMahon	Senior Lecturer in Clinical Psychology / Clinical Psychologist	University of Edinburgh / NHS Lanarkshire	Named Contact
Dr Rowan Reffold	Consultant Clinical Psychologist	NHS Tayside	Named Contact

Appendix F - Empirical Research: Participant Information Sheet

APPROPRIATE NHS LOGO TO BE ADDED HERE

Emilly Scott
Trainee Clinical Psychologist
NHS Tayside

PARTICIPANT INFORMATION SHEET

Working with People with Intellectual Disabilities and Behaviour that Challenges: Perspectives from Clinical Psychologists.

You are being invited to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish. Contact us if there is anything that is not clear or if you would like more information.

What is the purpose of the study?
To understand the perspectives of Clinical Psychologists working with people with intellectual disabilities and behaviour that challenges.

Why have I been asked to take part?
You have been invited to take part in this research because you are a Clinical Psychologist working within the NHS with people with intellectual disabilities and behaviour that challenges.

Do I have to take part?
No, it is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. Deciding not to take part or withdrawing from the study will not affect your legal rights. You have the right to ask that your recording and transcript are destroyed at any time. However, the analytic method used in this study means that it is difficult to

remove data when it has been included in the analysis. Therefore, you will have up until one month before thesis submission in May 2017 to withdraw your data.

Reimbursement for time
Participation is voluntary and participants will not receive any payment for their time.

What will I have to do?
Participation involves a face-to-face interview that will last approximately 30-60 minutes. The interview will be arranged at a time and place to suit you.

What will happen if I take part?
If you decide to take part, the researcher will be in contact to arrange a date, time and location for the interview to take place. Interviews may be conducted via video conferencing or Skype technology should it be difficult to arrange a mutually suitable time. You will be asked to sign a consent form and then be invited to talk about your experiences of working with this population, and asked a number of questions around this. The main topics that will be focussed on are your views of working with both staff teams and families, and the challenges that clinical psychologists may experience when working with this population.

The interviews will be recorded on a digital audio device, and will then be transcribed with the removal of any identifiers. All transcriptions will be securely stored. Interviews will be analysed using thematic analysis. Once analysis is complete, it will be sent to you to in order to provide you with the opportunity to review the themes. This is entirely voluntary, is not a requirement of participation. Reviewing of themes is expected to take around 30 minutes of your time. Your comments on the themes derived will help us to ensure responses have been interpreted correctly and to increase our understanding of the perspectives of clinicians working in this area.

As standard with this type of analysis, short anonymised quotations will be used within the thesis; it will not be possible to identify the individual or Health Board from the quotation. If you would rather not have any quotations from your transcript included, please inform the researcher.

What are the possible benefits of taking part?
It is hoped that the research will highlight both the positive aspects and the challenges that psychologists experience when working with this population. This may identify future recommendations for clinical psychologists working in this area. This information would contribute to the existing literature base, and be of value in directing future clinical practice and research.

What are the possible disadvantages and risks of taking part?
There is a risk that confidential information about patients is divulged during interview. You will be reminded prior to interview to avoid divulging confidential information. If this were to happen, any identifiable information would not be transcribed.

There is also a possibility that a participant may report practices that would cause concern around either their fitness to practice, or to the safety of a vulnerable adult or child. Should this occur, the researcher will follow relevant NHS Health Board and University of Edinburgh protocols to ensure the safety of vulnerable adults. Firstly, the researcher will discuss any concern with the clinical and research supervisors. If it is felt that a risk may be present, a supervisor will make contact with the participant and explain their concerns. If these concerns are not allayed, the participant's line manager will be contacted with regard to issues of fitness to practice. If there are concerns relating to a vulnerable adult or a child, and it is believed that appropriate steps to manage this risk have not been taken, contact with the relevant Social Work department will be made.

What if I want to find out more?
If you want to find out more please do not hesitate to contact the researcher Emilly Scott, Trainee Clinical Psychologist at escott11@nhs.net.
You can also contact Dr Ken MacMahon (Academic Supervisor, ken.macmahon@ed.ac.uk) or Dr Rowan Reffold (Clinical Supervisor, rowan.reffold@nhs.net) regarding the research should you require further information or should you have any concerns. Should you wish you contact someone independent to the research, please contact Dr. Angus Macbeth (Lecturer in Clinical Psychology; angus.macbeth@ed.ac.uk; 0131 651 3973) to discuss any questions or concerns you may have.

Will my taking part in the study be kept confidential?
It will not be possible to identify any of the individuals who take part in the study from the reports, as all the information will be anonymised. In addition, to ensure that the study is being run correctly, we will ask your consent for responsible representatives from the Sponsor and NHS Institution to access data collected during the study, where it is relevant to you taking part in this research. The Sponsor is responsible for overall management of the study and providing insurance and indemnity.

What will happen to the results of the study?
The results will be submitted as part of the University of Edinburgh Doctorate in Clinical Psychology programme. The study may be presented at relevant conferences (either through poster display or oral presentation), and will be submitted for publication in a relevant peer-reviewed journal.

Who is organising the research and why?
This study has been organised and sponsored by University of Edinburgh. The study is being undertaken to part fulfil the requirements for a Doctorate in Clinical psychology.

Who has reviewed the study?
The study proposal has been reviewed by the University of Edinburgh Ethics Review Board and given a favourable ethical opinion. NHS management approval has also been obtained.

How do I take part?
If you are interested in taking part in this research project, please return the attached Participant Expression of Interest form, or contact Emilly Scott

directly on escott11@nhs.net or on 07825 225293 to obtain more information.

Thank you very much for taking the time to read this information sheet.

If you wish to make a complaint about the study please contact NHS (insert NHS healthboard)

INSERT Address, Tel and email for the appropriate complaints department here

Appendix G - Empirical Research: Participant consent form

APPROPRIATE NHS LOGO TO BE ADDED HERE

Emilly Scott
Trainee Clinical Psychologist
NHS Tayside

CONSENT FORM

Working with People with Intellectual Disabilities and Behaviour that Challenges: Perspectives from Clinical Psychologists.

Please initial box

1. I confirm that I have read and understood the information sheet (Version 1: 11 Jan 2016) for the above study and have had the opportunity to consider the information and ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and without my legal rights being affected. ☐

3. I agree to my interview being recorded on an encrypted digital audio recorder and transcribed. ☐

4. I agree to being contacted after the interview to review the interpretations that the researcher has made of my interview. ☐

5. I understand and agree that some quotations from my interview may be contained within a doctoral thesis and may be used in publications that arise from this thesis. I understand that any quotations will be anonymised and I will not be identifiable from these. ☐

6. I understand that if any issues relating to patient safety or other risks are raised during the interview, the researcher will follow relevant NHS Health Board and University of Edinburgh protocols to ensure patient safety. ☐

7. I understand that relevant sections of data collected during the study may be looked at by individuals from the regulatory authorities and from the Sponsor (University of Edinburgh) or from the NHS Board where it is relevant to my taking part in this research. I give permission for those individuals to have access to my data. ☐

8. I agree to take part in the above study. ☐

_____	_____	_____
Name of participant	Date	Signature

_____	_____	_____
Name of person taking consent	Date	Signature

Original (x1) to be retained in site file
Copy (x1) to be retained by the participant

Appendix H - Empirical Research: Participant demographic questionnaire

APPROPRIATE NHS LOGO TO BE ADDED HERE

DEMOGRAPHIC INFORMATION

Working with People with Intellectual Disabilities and Behaviour that Challenges: Perspectives from Clinical Psychologists.

Gender:
Female Male

Ethinicity:
White – British
Irish
Scottish
Any other white background
Asian or Asian British – Indian
Pakistani
Bangladeshi
Any other Asian background
Mixed – White & Black Caribbean
White & Black African
White & Asian
Any other mixed background
Black or black British – Caribbean
African
Any other black background
Other ethnic group – Chinese
Any other ethic group: specify _____
I do not wish to disclose my ethnic origin

Participant age range:

18-25	26-30	31-35	36-40
41-45	46-50	51-55	56-60

61-65

Number of years working with this population as a clinical psychologist:

1-5	6-10	11-15	16-20
21-25	26-30	31-35	36-40

Number of years working with this population in an alternative role:

None

1-5	6-10	11-15	16-20
21-25	26-30	31-35	36-40

Any experience of working within a long-stay inpatient hospital as a clinical psychologist?

Yes No

If yes: _____

Any experience of working within a long-stay inpatient hospital in an alternative role?

Yes No

If yes: _____

Appendix I - Empirical Research: Semi-structured interview guide

Your experience:

- Tell me about your experience working with ID & CB
- Pre-qualification experience
- Experience during training
- Experience post-qualification

(post, time, context)

Your service:

- Tell me about the service you currently work in.
- How is it structured?
- How does the service work for people with CB?

Theoretical approach:

- What theoretical approach would you tend to take?
- What approach do other professions within your service take?

Working with others:

- Experiences of working with staff teams?
- Experiences of working with families?
- Experiences of working with other professionals?

Personal:

- How does this work affect you?
- How do you manage?

Prompts

Can you give me an example of?
Tell me about a time when..
Can you tell me more about?
Challenges and benefits?
Characteristics of that make easier/more challenging?

Appendix J - Empirical Research: Coded transcript sample

ones that really hit home that they attribute in a different way to actually the acts of physical aggression erm because they can be very very severe erm you know the erm (long pause) people can then have injuries where they're off sick for weeks as a consequence of their injuries so yes trying to keep the formulation front and centre but acknowledging that it can happen erm it's not you know we're not we think we know the reasons why it happens erm but we can never say that in a perfect environment this will never happen you know no guarantees and that is a difficult decision then for... social work it's a difficult thing of them to hear, that kind of yeah but we can't guarantee yeah erm so that's what we're trying to do just now is keep him on the delayed discharge list and... erm we've got a discharge package prepared we've got a full comprehensive analysis of his behaviour, we've got what his ideal day would look like we've got the kind of PBS package if you like of what it should be, working with him in collaboration with him but the risks are a barrier for other agencies to fund that

Emilly
Yeah, tricky, can't make promises

Participant 9
No, absolutely not

Emilly
Ok great, erm... can you tell me a bit about working with families if you've got yeah and maybe how that's different from working with staff teams

Participant 9
Yeah (long pause) yeah erm yeah I've have a lot one of my special interests is working with families under stress I do BFT I'm a BFT trainer

Emilly
And would you use BFT with challenging behaviour, behaviour that challenges

Participant 9
Yes, yeah If erm if I think if we formulate that one of the significant maintaining factors in the clinical presenting behaviour in the clinical presenting problem in this case it may be challenging behaviour is high levels of stress within the family then yes we would erm offer challenging behaviour erm in those circumstances and you know our population this population have multiple presenting problems and multiple diagnoses often so it's yeah you'll often see challenging behaviour as a presenting difficulty in amongst a list erm (long pause)I really enjoy working with families, I really enjoy working with staff teams but I also really enjoy working with families erm (long pause) often I don't know if its they're much more open, I don't know if that's

a sweeping attribution I'm now thinking about what I'm about to say and catching myself (laughs)

Emilly
(laughs) it's ok

Participant 9
I guess you get the full range of. (long pause) kind of difficulties between a complete open approach to you know a complete buy in for a psychological intervention and you get the opposite end of the spectrum where you'll see a 'no hen we've tried that' erm you know we've done this all before and I think the issue with supporting families that we have to remember is it's often 24/7 there's a chronicity especially with challenging behaviour there's often a chronicity that we can't even comprehend so whilst the level of stress with our supporting teams, our paid support work are really really high that can only be much more complex with families when it's 24/7, it's chronic we say that staff teams have had no training in other kind of models or kind of understanding the communicative function of challenging behaviour families have normally had none, that would pretty much be standard or often had none and they have the emotional attachment which makes it much more complicated erm and much more... supportive as well they often want to effect change erm and the fact you know as I say I work with the more extreme end or the more severe end of challenging behaviour so we're often seeing them at times of significant distress erm and yeah having a multi-disciplinary approach to supporting a family through that can be erm can be a real challenge but very very rewarding erm

Emilly
And what are some of the other challenges of working with families?

Participant 9
I think that they get the appropriate level of support. Erm we can create the most beautiful PBS framework (long pause) part of that is it has to be realistic and in the current climate getting access to things like respite or appropriate kinda paid support I don't mean you know respite as in someone has access to a respite place you know once every 2 months or once every month erm is one kind of but a daily respite as well that they have a life of their own that isn't just about being such and such's sister, mother, brother erm that can be really really challenging especially you know they've in most cases it's just the way it's been whilst we know the theory of putting their life and their goals and having a place for that in their lives and in some ways I think that sometimes just us putting our values we know that the evidence base is there that if you have your own goals and your individual aspirations and you've got a supportive network to make sure you get that and that's healthy for your mental health and that's you know a kind of respite in effect from that but some families, one of the things that I struggle to get families to do is think of themselves erm

Emilly
Because they've always just thought of the other person

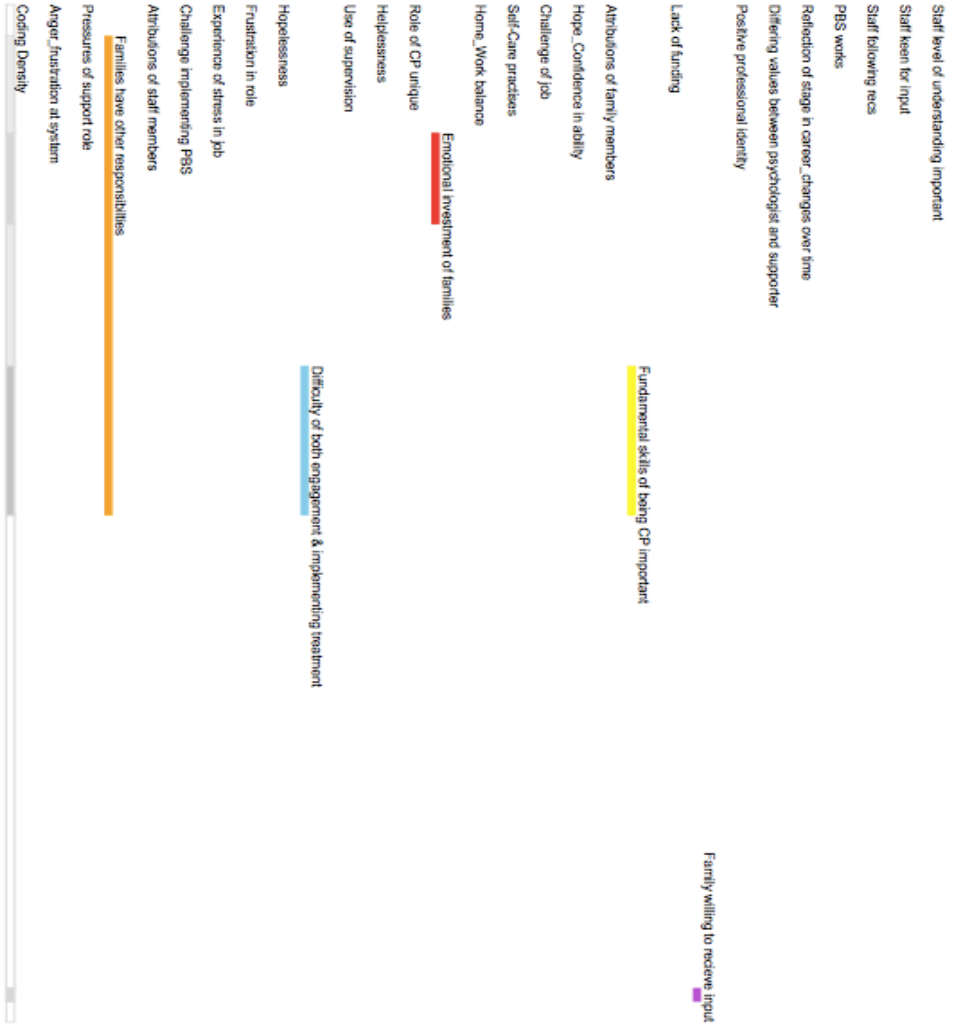
Participant 9
They just. If you could just make this situation better, that would be that would be you know that would work for me that's what I need, and to try and actually get them to think of themselves to see themselves as a person outwith that context is a real challenge I mean I've worked with family members for 2 and 3 sessions but what about you, what about before such and such, what did you do then, what did you enjoy, what were your goals, you know what were your aspirations but 'none of that matters hen' so you get a a real erm yeah it's a real different perspective for people who's whole life has been consumed by the by caring the caring needs of their loved one erm and that can be and getting them access to support to make sure they have a break and that they've got you know time for themselves and time for meaningful activities for them you know things like you know being able to maintain a job you know it's and not just challenging behaviour I think of challenging behaviour but you know epilepsy if you're supporting someone with complex epilepsy and they're very distressed because how can they hold down their job or you know you know the whole kind of system of benefits and things like that and we often work with people with challenging behaviour who their families live in very (long pause) socially deprived circumstances erm these can be families who traditionally would be difficult to engage erm and so when you then have someone in that environment with a learning disability and mental health problems and challenging behaviour at the same time that trying to get a foot in the door can be a real challenge and as I say the same principles I think that working with staff teams apply when working with families that you are seen as human first and foremost erm that we work in collaboration, that it's non judgemental, obviously keeping the safety of the person and the wellbeing of the person front and centre but that we're non judgemental we work with you erm and we acknowledge that you're absolutely doing the very best you can with the resources you have available that's the principle that we work and then if they feel that they're much more willing to kind of work with you I think yeah, that would be the in my experience of working with families (laughs) sorry I smile every time I say I'm working with families

Emilly
Ah (laughs) you really love it

Participant 9
Yeah, I really do

Emilly
And do you find, so if you were to give erm a staff team some guidelines of what to do I know you said kind of you start small changes and but if you were to give them kind of suggestions and things do you find that there's a difference in would you say that families do more of what you suggest because like you say they're more invested

Participant 9
It's variable, I think you have to see it as a psychologist you have to see it as a very much an individual circumstance, of individual staff team, no 2 staff teams, no 2 inpatient staff teams are the same no 2 families, no 2 set of circumstances are the same. So you've got to if you like just assess it as it presents. Do I think... in some cases I can think of families and they've absolutely



went great guns with you know with implementing, recording you know ABC charts they have done them diligently they have you know they have to the letter implemented everything you've asked for and then I can think of families that 'we've done that hen' you know before you even suggest one thing (laughs)

Emilly
(laughs) yeah, done it, tried that

Participant 9
yeah, and it's just it's a case by case basis and I think with working with families probably much more than actually working with staff teams it's a slightly different approach. Working with families it's what causes you stress what do you find really stressful and if you can get that as your starting point of incorporating what they need your help with and reducing that challenge and you know it might be something that I would look at and think well that's not the most significant presenting issue here but for that person it might be erm and you know that's it's about holding judgement and letting them prioritise what causes stress to them. I probably wouldn't do the same with a staff team I'd try and look at it much more objectively and say what's having the greatest impact on this person's quality of life their ability to engage because with a staff team you're working with so many different members of staff that my expectation is that they do implement the what I'm asking erm or what the treatment the formulation would suggest erm but with families if you can get the propensity by affecting something that's really significant to them then they're likely to get bang in likely to be engaged and if you can get engagement you can then work on the other behaviours that are maybe much more threatening to the community inclusion, the person's quality of life or meaningful activity or capacity to be included into the community erm so yeah, just thinking about that actually I probably do something slightly differently it's taking into account what the family member thinks you know experiences as very distressing.

Emilly
Mmhmm

Participant 9
Don't get me wrong if it's very significant self-injurious behaviour and they're not telling me that, you know they're wanting something different then I'll probably you know support them to you know work on more than one thing but with a staff team it seems much more, you try and be much more objective to the to you know whats making the biggest impact on this person's quality of life

Emilly
Yeah. Do you find that there are any erm differences in attributions between staff teams and families?